Alberta

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Health and Wellness

Annual Report
2009-2010

Government of Alberta

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Health and Wellness

Annual Report 2009 – 2010

Preface

1 Public Accounts 2009/2010
3 Minister's Accountability Statement
5 Message from the Minister
7 Management's Responsibility for Reporting

8 Overview
8 Ministry of Health and Wellness Organization
9 Vision, Mission and Core Businesses

10 Results Analysis
10 Auditor General's Report
11 Performance Measures Summary Table
13 Goal 1: Effective governance for the health system
15 Goal 2: A sustainable and accountable health system
18 Goal 3: Healthy people in healthy communities
23 Goal 4: Strong public health capacity to mitigate risk and enhance population health
26 Goal 5: Enhance health workforce collaboration, development and capacity
30 Goal 6: Increase access through effective service delivery
36 Goal 7: Improve health service efficiency and effectiveness through innovation and technology
40 Integrated Results Analysis
42 Changes to Performance Measure Information
44 Performance Measures – Data and Methodology

54 Financial Information
54 Ministry Financial Highlights
57 Ministry Financial Statements
85 Department Financial Statements
115 Ministry Unaudited Information
117 Health Authority Financial Statement Highlights
119 Alberta Health Services Financial Statements
183 Health Quality Council of Alberta Financial Statements

197 Ministry Contacts

Preface

Public Accounts 2009/2010

The Public Accounts of Alberta are prepared in accordance with the *Financial Administration Act* and the *Government Accountability Act*. The Public Accounts consist of the annual report of the Government of Alberta and the annual reports of each of the 24 ministries.

The annual report of the Government of Alberta released June 24, 2010 contains Ministers' accountability statements, the consolidated financial statements of the province and *The Measuring Up* report, which compares actual performance results to desired results set out in the government's business plan.

This annual report of the Ministry of Health and Wellness contains the Minister's accountability statement, the audited financial statements of the ministry and a comparison of actual performance results to desired results set out in the ministry business plan. This ministry annual report also includes:

- **the financial statements of entities making up the ministry including the Department of Health and Wellness and provincial agencies for which the minister is responsible, and**
- **other financial information as required by the *Financial Administration Act* and *Government Accountability Act*, either as separate reports or as a part of the financial statements, to the extent that the ministry has anything to report.**

For financial information relating to Alberta Health Services, which is accountable to the Minister of Alberta Health and Wellness, please visit the Alberta Health Services website at www.albertahealthservices.ca.

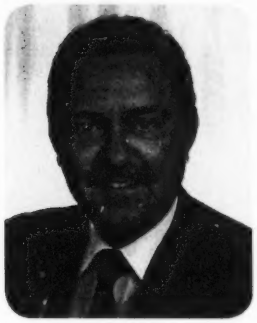
Minister's Accountability Statement

The ministry's annual report for the year ended March 31, 2010, was prepared under my direction in accordance with the *Government Accountability Act* and the government's accounting policies. All of the government's policy decisions as at September 16, 2010 with material economic or fiscal implications of which I am aware have been considered in the preparation of this report.

[Original signed by]

Gene Zwozdesky
Minister of Health and Wellness

Message from the Minister



Since being appointed Minister of Health and Wellness in January 2010, I have travelled across Alberta listening carefully to the concerns of Albertans and to those of health care stakeholders. I have also been strengthening relationships with Alberta Health Services (AHS) and the organizations that have a direct responsibility in running the public health system. It has been exciting and important work, and has provided me with great insight into what Albertans, including our health care partners, feel are the critical issues that we must address.

In 2009/2010, Alberta — like all provinces — was faced with a number of fiscal challenges due to the world-wide recession. Each government ministry took action by looking internally at ways to more efficiently provide services to Albertans. The collective saving resulting from those efforts helped lower the deficit and improve government's fiscal position, which allowed for reinvestment of saving into priority areas such as health care.

Alberta's health system also faced many challenges in 2009/2010, including the growing pains of amalgamating 12 health entities into one health services delivery arm, and addressing a large projected deficit facing Alberta Health Services, which was raising anxieties about our health care system. In the midst of all of that, Alberta — like all provinces — was also dealing with and responding to the emergence of the pandemic H1N1 influenza virus, culminating in the successful management of the second wave of infections between October and December 2009.

In February 2010, the Alberta Government responded with our first-ever 5-year funding commitment for health. This commitment brought certainty to the system with predictable, stable funding that will allow AHS to improve long-range planning to increase access, reduce wait times and improve health outcomes. The Alberta Government also eliminated the aforementioned deficit and increased AHS base operating funding by more than $800 million.

Committing to a 5-year funding plan was not the only highlight in 2009/2010. The Minister's Advisory Committee on Health, launched in September 2009, completed a review of health legislation with a focus on improving health system performance and patient care. In January 2010, the committee released its report which included four broad recommendations, including developing a new *Alberta Health Act*. The report also recommended developing an Alberta health charter, consolidating core legislation and establishing an arm's-length entity to support evidence-based decision-making. The Alberta Government continues to engage Albertans in this important work.

Other important developments in 2009/2010 included:

- transitioning the delivery of emergency medical services from municipalities to AHS;
- rolling out the Alberta Pharmaceutical Strategy (The strategy focuses on changes to government-funded drug plans, lowering the prices of new and existing generic drugs and expanding the role of pharmacists);
- proclaiming the *Mental Health Amendment Act 2007* (This legislation introduced community treatment orders that are designed to help Albertans who have serious and persistent mental disorders continue their treatment while living in their community);

- the integration of addiction and mental health services including opening 51 new addiction and mental health treatment beds;
- introducing a new stroke hotline, the TIA (transient ischemic attack) hotline, to allow physicians in rural and urban areas to consult with stroke neurologists when a patient is at risk for or having symptoms of a stroke;
- announcing the expansion of the Stollery Children's Hospital emergency department;
- bringing midwifery services into the publicly funded health system; and
- recognizing Albertans for promoting healthy choices for children, and supporting healthy living in Alberta's communities.

Within the department of Alberta Health and Wellness, a new reporting structure was created, expanding the role of the Chief Medical Officer of Health. Two new senior medical officers of health joined the team and as a result, a more rapid and comprehensive surveillance system was created to quickly detect and manage influenza outbreaks. This team demonstrated strong leadership throughout the pandemic H1N1 response by providing medical expertise to improve or safeguard the health of all Albertans.

As I look back on the accomplishments of 2009/2010, I can see the ministry is moving into a new era of stability. The positive results of a new governance structure and the funding allocated over the next 5 years will support the operational side of the health system, allowing for improved quality and access to health services.

I am very inspired in my work, in part because of the dedicated, knowledgeable and highly skilled staff in this department, and because of the commitment and expertise of our partners and the thousands of physicians, nurses and other care providers who deliver health services to Albertans.

Together, this ministry and our partners will continue emphasizing the "care" in health care, while also increasing the focus on the wellness agenda for Albertans. Through collaboration and strong leadership, we will achieve our Premier's vision of "the best-performing publicly funded health system in Canada".

Thank you for helping us get there!

[Original signed by]

Gene Zwozdesky
Minister of Health and Wellness

Management's Responsibility for Reporting

The executives of the individual entities within the ministry have the primary responsibility and accountability for the respective entities. Collectively, the executives ensure the ministry complies with all relevant legislation, regulations and policies.

Ministry business plans, annual reports, performance results and the supporting management information are integral to the government's fiscal and business plans, annual report, quarterly reports and other financial and performance reporting.

Responsibility for the integrity and objectivity of the financial statements and performance results for the ministry rests with the Minister of Alberta Health and Wellness. Under the direction of the Minister, I oversee the preparation of the ministry's annual report, including financial statements and performance results. The consolidated financial statements and the performance results, of necessity, include amounts that are based on estimates and judgments. The financial statements are prepared in accordance with the Canadian generally accepted accounting principles for the public sector as recommended by the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants. The performance measures are prepared in accordance with the following criteria:

- Reliability — Information agrees with the underlying data and the sources used to prepare it.
- Understandability and Comparability — Actual results are presented clearly and consistently with the stated methodology and presented on the same basis as targets and prior years' information.
- Completeness — Performance measures and targets match those included in Budget 2009. Actual results are presented for all measures.

As Deputy Minister, in addition to program responsibilities, I establish and maintain the ministry's financial administration and reporting functions. The ministry maintains systems of financial management and internal control which give consideration to costs, benefits, and risks that are designed to:

- provide reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations and properly recorded so as to maintain accountability of public money;
- provide information to manage and report on performance;
- safeguard the assets and properties of the Province of Alberta under ministry administration,
- provide Executive Council, Treasury Board, the Minister of Alberta Finance and Enterprise, and the Minister of Alberta Health and Wellness any information needed to fulfill their responsibilities; and
- facilitate preparation of ministry business plans and annual reports required under the *Government Accountability Act*.

In fulfilling my responsibilities for the ministry, I have relied, as necessary, on the executive of the individual entities within the ministry.

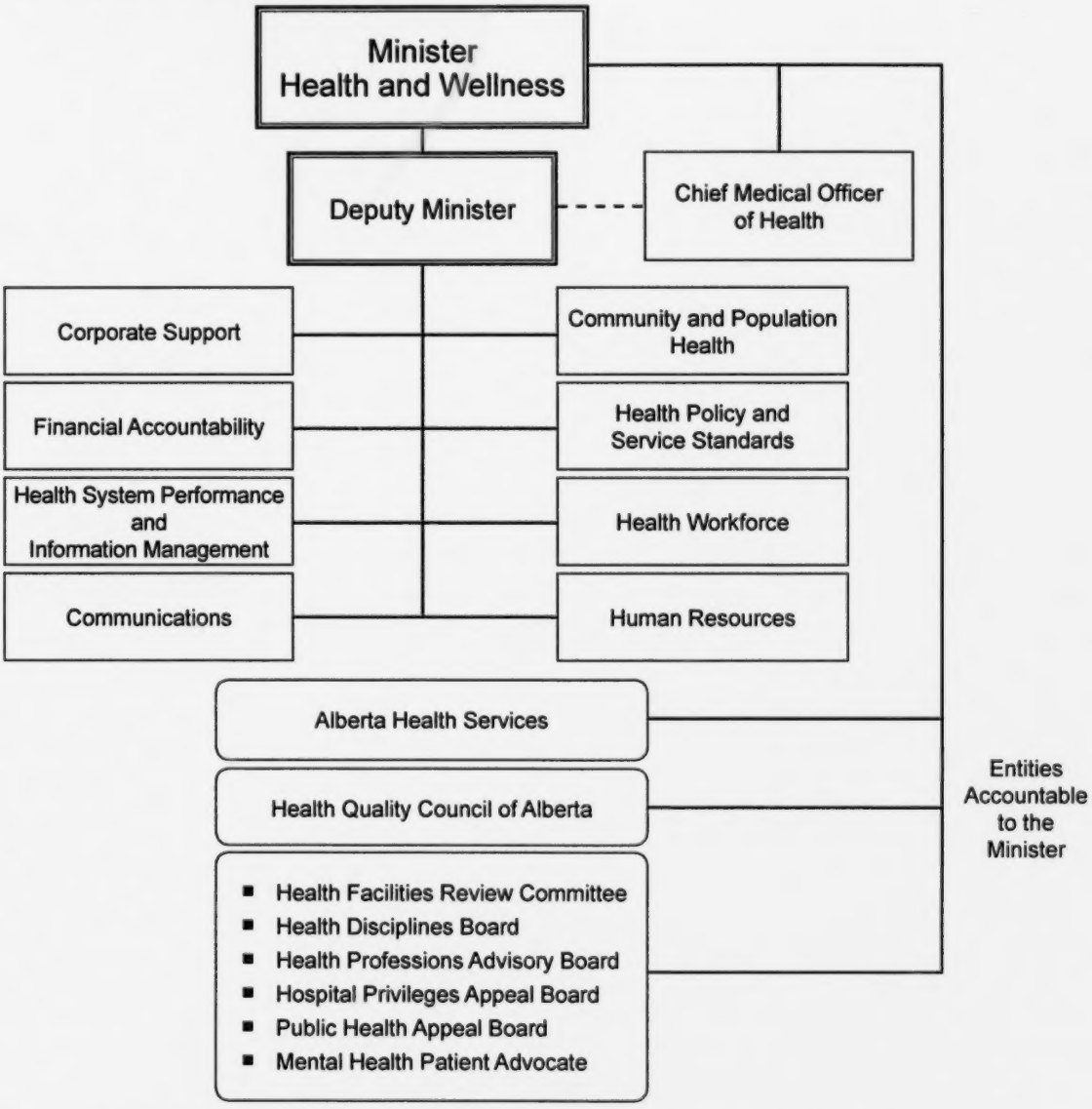
[Original signed by]

Jay G. Ramotar
Deputy Minister
Alberta Health and Wellness
September 16, 2010

Ministry Overview

Ministry of Health and Wellness Organization

(For the year ended March 31, 2010)



The ministry's focus and role is strategic in developing policy, setting standards and regulations, ensuring accountability, and pursuing innovations on behalf of Albertans. Alberta Health Services delivers health services in response to direction received from the ministry. Alberta Health Services produces its own Strategic Direction Plan, Annual Report and other public information. These reports contain additional information on the delivery of health services, the costs of providing programs as well as significant achievements, and can be accessed at www.albertahealthservices.ca.

Vision, Mission and Core Businesses

Vision: *Healthy Albertans in a Healthy Alberta.*

The achievement of this vision is everybody's responsibility. The Ministry of Alberta Health and Wellness plays a leadership role in achieving this vision through our mission, core businesses and goals.

Mission: *Build a high-performing, effective and accountable health system.*

The ministry fulfills this mission through three core businesses, each of which is supported by corresponding business plan goals.

Core Business 1: Strengthen health system leadership and sustainability.

Goal 1 — Effective governance for the health system.

Goal 2 — A sustainable and accountable health system.

Core Business 2: Promote and support healthy living and wellness.

Goal 3 — Healthy people in healthy communities.

Goal 4 — Strong public health capacity to mitigate risk and enhance population health.

Core Business 3: Enhance health service access, quality and performance.

Goal 5 — Enhance health workforce collaboration, development and capacity.

Goal 6 — Increase access through effective service delivery.

Goal 7 — Improve health service efficiency and effectiveness through innovation and technology.

Results Analysis

Auditor General's Report

Review Engagement Report

To the Members of the Legislative Assembly

I have reviewed the performance measures identified as "Reviewed by Auditor General" included in the *Ministry of Health and Wellness' 2009-10 Annual Report*. These performance measures are prepared based on the following criteria:

- Reliability – Information agrees with the underlying data and with sources used to prepare it.
- Understandability and Comparability – Actual results are presented clearly and consistently with the stated methodology and presented on the same basis as targets and prior years' information.
- Completeness – performance measures and targets match those included in Budget 2009. Actual results are presented for all measures.

My review was made in accordance with Canadian generally accepted standards for review engagements and, accordingly, consisted primarily of enquiry, analytical procedures and discussion related to information supplied to my Office by the Ministry. My review was not designed to provide assurance on the relevance of these performance measures.

A review does not constitute an audit and, consequently, I do not express an audit opinion on these performance measures.

Based on my review, nothing has come to my attention that causes me to believe that the "Reviewed by Auditor General" performance measures in the Ministry's 2009-10 Annual Report are not, in all material respects, presented in accordance with the criteria of reliability, understandability, comparability, and completeness as described above. However, my review was not designed to provide assurance on the relevance of these performance measures.

[Original signed by Merwan N. Saher]

CA
Auditor General

Edmonton, Alberta
September 16, 2010

Performance Measures Summary Table

Core Businesses/Goals/Performance Measure(s)		Prior Years' Results				Target	Current Actual
Core Business 1: Strengthen health system leadership and sustainability							
1.	**Effective governance for the health system**						
1.a*	Public rating of health system overall: percentage rating the health care system as either "excellent" or "good"	65% 2006	55% 2007	60% 2008	63% 2009	**65%**	65% 2010
2.	**A sustainable and accountable health system.**						
2.a	Annual ministry operating expense: percentage change over prior year actual.	—	—	—	10.8% 2008/09	**4.7%**	6.1% 2009/10
2.b*	Incidence of serious complaints: percentage of Albertans reporting a serious complaint about any health care services personally received in the past year in Alberta	15% 2003	15% 2004	14% 2006	13% 2008	**13%**	13% 2010
Core Business 2: Promote and support healthy living and wellness							
3.	**Healthy people in healthy communities**						
3.a	Self reported health status: percentage of Albertans reporting "excellent", "very good", or "good" health						
	(1) 18 to 64 years	88%	87%	88%	89%	**90%**	88%
	(2) 65 years and over	86% 2006	78% 2007	84% 2008	84% 2009	**85%**	88% 2010
3.b	Healthy weight: percentage of Albertans age 18 and over with an "acceptable" body mass index (BMIs 18.5 to 24.9)	46% 2003	46% 2005	45% 2007	45% 2008	**47%**	42% 2009
3.c	Influenza immunization: percentage who have received the recommended annual influenza immunization						
	(1) Seniors aged 65 and over	68%	62%	60%	58%	**75%**	55%
	(2) Children aged 6 to 23 months	59% 2005/06	52% 2006/07	64% 2007/08	43% 2008/09	**75%**	— 2009/10
3.d*	Smoking: prevalence of smoking						
	(1) Alberta youth 12 to 19 years.	14%	11%	12%	11%	**10%**	13%
	(2) Young adults 20 to 24 years	37% 2003	33% 2005	30% 2007	26% 2008	**29%**	25% 2009
3.e	Regular heavy drinking: prevalence of regular, heavy drinking among young Albertans	38% 2003	38% 2005	40% 2007	40% 2008	**30%**	40% 2009
4.	**Strong public health capacity to mitigate risk and enhance population health**						
4.a	Sexually transmitted infection: Syphilis. Rate of newly reported infections (per 100,000 population)	4.5 2005	6.6 2006	7.3 2007	7.0 2008	**6.5**	7.4 2009
4.b*	Patient safety: percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year	14% 2003	13% 2004	13% 2006	10% 2008	**11%**	9% 2010
4.c	Confidence in the public health system: percentage of Albertans satisfied with health care services personally received in Alberta within the past year		52% 2004	58% 2006	60% 2008	**60%**	61% 2010

Core Businesses/Goals/Performance Measure(s)		Prior Years' Results				Target	Current Actual
Core Business 3: Enhance health service access, quality and performance.							
5.	**Enhance health workforce collaboration, development and capacity.**						
5.a*	Access to primary care through Primary Care Networks: percentage of Albertans enrolled in a Primary Care Network	— 2005	— 2006	— 2007	55% 2008	**55%**	— 2009
6.	**Increase access through effective service delivery**						
6.a	Wait time for:						
	(1) Heart surgery (coronary artery bypass graft — 90th percentile wait times in weeks, by urgency level)						
	Urgency Level I	7	4	2	2	**2 weeks**	2 weeks
	Urgency Level II	14	18	14	20	**6 weeks**	21 weeks
	Urgency Level III	23 2005/06	34 2006/07	26 2007/08	18 2008/09	**26 weeks**	17 weeks 2009/10
	(2) Hip replacement surgery*† 90th percentile wait time in weeks	51 2005/06	43 2006/07	36 2007/08	36 2008/09	**26 weeks**	35 2009/10
	(3) Knee replacement surgery*† 90th percentile wait time in weeks	63 2005/06	53 2006/07	49 2007/08	46 2008/09	**26 weeks**	49 2009/10
	(4) Children's mental health services 90th percentile wait time in weeks	10 2005/06	11 2006/07	10 2007/08	11 2008/09	**10 weeks**	10 weeks 2009/10
6.b	Public rating of access to emergency department services: percentage rating ease of actually obtaining emergency department services needed for self as "easy"	—	46% 2003	50% 2004	48% 2006	51% 2008	**60%**	55% 2010
6.c	The number of persons waiting in an acute care hospital bed for continuing care placement	—	—	—	645 2007/08	754 2008/09	**505**	707 2009/10

Core Businesses/Goals/Performance Measure(s)		Prior Years' Results				Target	Current Actual
7.	**Improve health service efficiency and effectiveness through innovation and technology**						
7.a*	Number of care providers accessing Alberta Netcare	18,675 2005/06	22,918 2006/07	29,110 2007/08	34,200 2008/09	**29,500**	39,866 2009/10
7.b	Percentage of Albertans who are aware of Health Link Alberta	66%	67%	71%	71%	**73%**	76%
	Percentage of Albertans who have used Health Link Alberta within the past year	39% 2006	37% 2007	33% 2008	37% 2009	**42%**	36% 2010
7.c	Percentage of community physicians enrolled in the Physician Office System Program (POSP) and using the electronic medical record in their clinic	—	42% 2007	45% 2008	45% 2008/09	**48%**	46% 2009/10

* **Indicates Performance Measures that have been reviewed by the Office of the Auditor General**
The performance measures indicated with an asterisk were selected for review by ministry management based on the following criteria established by government:

1. Enduring measures that best represent the goal and mandated initiatives,
2. Measures that have well established methodology and data reporting,
3. Measures that have outcomes over which the government had a greater degree of influence, and
4. Each goal has at least one reviewed performance measure.

Note: Measure 5.a. Access to primary care through Primary Care Networks - Results for 2009/2010 are not available as of August 26, 2010.

† **Note:** Measures 6.a.2 and 6.a.3. Wait time for hip replacement surgery; Wait time for knee replacement surgery. Results are restated for all prior years due to changes in methodology. Calculation of results is now based on data for the entire fiscal year, not data 90 days prior to the last day of March.

For more detailed information, see the Performance Measures — Data Sources and Methodology section of the annual report, pages 44 to 53.

Goal 1: Effective governance for the health system

Linked to Core Business 1 — Strengthen health system leadership and sustainability

With Alberta's new governance model, there is an opportunity to further clarify roles between the ministry and Alberta Health Services. Effective governance means that each player knows their respective role in the health system and is accountable for pursuing their respective mandate, meeting their ongoing responsibilities and obligations, and working collaboratively with one another to ensure that the policy and delivery arms of health are aligned in the interests of Albertans. Effective governance also involves an ongoing review of the ministry's vision and mission to ensure we continue to work towards a renewed health system for Alberta.

Achievements

Strategy 1.1 **Provide leadership and support for the transition of Emergency Medical Services (EMS) to Alberta Health Services.**

- The transition of EMS from municipalities to Alberta Health Services (AHS) occurred April 1, 2009. This change included transferring the governance and funding of EMS services for better integration with the health care system.
- On April 1, 2009 AHS began the consolidation of 35 EMS dispatch centres across the province with the target set to consolidate to three. This consolidation is one of the key components of the EMS transition. AHS had completed 17 EMS dispatch consolidations by March 2010 when the Minister directed AHS to temporarily suspend further dispatch transitions for the time being. Although the Minister continues to support consolidation of dispatch as an important fundamental of the new model, the temporary halt will allow AHS time to review the consolidations that have occurred.
- The Ambulance Vehicle Standards Code January 2010 was implemented to bring into force updated minimum vehicle standards for licensed ambulances within the emergency health services system. This code will improve patient, public and practitioner safety.

Strategy 1.2 **Implement *Vision 2020*, including options to achieve health system sustainability.**

- The Minister's Advisory Committee on Health was appointed to ensure appropriate legislation is in place to allow for improved health system performance and patient care, and will enable many of the measures in Vision 2020 which are designed to strengthen the health system. The Committee's report, released January 2010, recommended that Government:
  - Articulate a set of principles that must be sustained and maintained throughout Alberta's Health System;
  - Legislate an Alberta Health Act for the future;
  - Ensure ongoing citizen engagement in the development of legislation, regulation and policy; and
  - Develop a clear guide to align legislative, regulatory, policy and program delivery changes across the health system.

Strategy 1.3 **Lead the capital planning process by preparing complete business case analysis based on service optimization recommendations.**

- Government tabled a three-year health care capital plan valued at nearly $3 billion, with a focus on patient-centred care and improved access. The capital plan will aim to relieve pressure on the acute care system and emergency rooms, introduce more integrated health care to better match resources with patient needs, and enhance supportive living models of continuing care.

Strategy 1.4 **Implement the transition to a new single health authority and further clarify roles and responsibilities.**

- As part of implementing the government's plan for improving the health care system, Alberta Health Services became officially operational on April 1, 2009. Alberta Health Services is responsible for delivering health services to Albertans in response to direction received from the Minister.

Key Performance Measure and Result

Measure 1.A **Public rating of health system overall**

This measure identifies Albertans' rating of the health care system and the quality of medical services it provides. Several factors may contribute to public rating of the health system including perceived ease of access to family physicians and medical specialists, wait times for health care services for oneself or family members, the quality of health care services experienced, and the perceived responsiveness of the health system to individual and community needs.

The Health Quality Council of Alberta (HQCA) 2010 survey of Albertans age 18 and older found that 65 per cent rated the health system overall as excellent or good, up from 63 per cent in 2009. This result meets the 2009/2010 target of 65 per cent.

The Minister's Advisory Committee on Health released its report in January 2010. Key recommendations in this report are to put people and their families at the centre of their health care, improve quality and safety, ensure equitable access to timely and appropriate care, develop a health charter for Alberta, and revise provincial health legislation.

Public rating of health system overall

	2006	2007	2008	2009	2010	Target 2009/2010
Public rating of health system overall: percentage rating the health care system as either "excellent" or "good"	65%	55%	60%	63%	65%	**65%**

Source: Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2006, 2007, 2008, 2009). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

Goal 2: A sustainable and accountable health system

Linked to Core Business 1 — Strengthen health system leadership and sustainability

A sustainable health system is one that is accountable, operates efficiently, is cost-effective and is able to balance patients' needs with limited financial resources. The ministry's role is to ensure that strategies are developed and implemented to improve health system productivity and achieve greater value for money. Being accountable for the health system means measuring results, assuring Albertans an enhanced quality of services, and evaluating effective programs in the interests of continuous service improvement and enhanced health system outcomes.

Achievements

Strategy 2.1 **Implement a procurement strategy to optimize the buying capacity of our health system.**

- The department contracted the development and early implementation of a strategic approach to procurement in the new single health region, Alberta Health Services (AHS). This work was conducted in collaboration with AHS and included transferring and aligning the existing procurement capacity from the previous nine regional health authorities to AHS.

Strategy 2.2 **Collaborate with the Health Quality Council of Alberta and Alberta Health Services to develop a monitoring and reporting framework for health services and issue a report on the quality of health care and service delivery.**

- The Health Quality Council of Alberta released its first annual report on quality measurement in Alberta, entitled: *2009-Measuring and Monitoring for Success*. This report provides a snapshot of the measurement of quality and safety in Alberta, and includes examples of innovative approaches to service delivery that demonstrate quality improvement.

Strategy 2.3 **Build public confidence and strengthen the public's trust in the health care system by enhancing our consolidated and integrated compliance function.**

- The department monitored continuing care facilities for compliance with the *Continuing Care Health Service Standards* and relevant *Infection Prevention and Control Standards*, and began publishing the results on its internet site in August 2009. These results also can be found on the Alberta Seniors and Community Supports' website where Albertans can review reports related to continuing care facility compliance with both continuing care health standards and accommodation standards.

Strategy 2.4

Implement the Pharmaceutical Strategy to improve drug coverage for seniors, a single government sponsored drug plan and more timely and transparent drug review process.

- The implementation of the improved coverage for seniors has been delayed to address the required legislative and regulatory changes. Framework and issue identification for consolidation of drug programs has been completed and is now dependent upon regulation development for the *Drug Program Act* which will allow for proclamation. The drug review process has been streamlined and expedited reviews are in place, additionally, a number of transparency initiatives to our Alberta Health and Wellness Drug Benefit List have been implemented.
- As part of the Alberta Pharmaceutical Strategy, government announced in October 2009 that the price of currently available or existing generic drugs will be immediately reduced from 75 per cent to 56 per cent of the price of comparable brand name drugs. In an additional step, new generic drug prices were reduced to 45 per cent of the price of comparable brand name drugs. This change took effect April 1, 2010.
- An on-line, interactive Drug Benefit List was developed to provide an effective web-based tool Albertans could use to determine the coverage status of drugs under various government plans. Additionally, information about the drug review process was included to increase the transparency of the drug review process.

Strategy 2.5

Explore and implement common procurement systems with other provinces.

- Alberta signed a joint purchasing agreement with British Columbia in July 2009. Under the agreement, the two provinces will contract with a group purchasing organization for bulk purchases of health system supplies and services, including medical and hospital supplies. Alberta will also include food and drug purchases as part of the agreement. These measures will decrease the cost-per-item for many supplies in both provinces, leaving a larger portion of the budget for patient health services.

Key Performance Measures and Results

Measure 2.A

Annual ministry operating expense: percentage change over prior year actual

A sustainable health system is accountable, cost effective and able to balance patients' needs with available financial resources. As rising health costs and expenditures affect the sustainability of the health system, it is important to monitor health spending trends of the department.

Significant reasons for the 6.1 per cent increase in department operating costs between 2008/2009 actual expenses and 2009/2010 actual expenses are:

- Increase in physician services costs as a result of contractual increases under the Tri-lateral master agreement as well as volume increases.
- Increase in funding to Alberta Health Services for increases in operations and one-time funding to address the 2008/2009 accumulated deficit of the former health authorities.
- Increase due to costs incurred to address the H1N1 pandemic response.

Annual ministry operating expense: percentage change over prior year actual

	2008/ 2009	2009/ 2010	Target 2009/2010
Annual ministry operating expense: percentage change over prior year actual	10.8%	6.1%	**4.7%**

Source: Department of Health and Wellness audited financial statements.

Measure 2.B Incidence of serious complaints

The information patients provide through the concerns/complaints process is an aspect of a patient feedback mechanism. From a health provider point of view, receiving patient complaints promotes a culture of reporting and accountability (Health Quality Council of Alberta, 2007).

In April 2007 the Health Quality Council of Alberta released the Patient Complaints/Concerns Resolution Provincial Framework. This Framework outlines a process for effectively and consistently handling patient complaints and concerns across and between Alberta Health Services, health providers and the regulated health professions. The management of complaints demonstrates a commitment to service and can be a mechanism to improve the delivery of care (HQCA, 2007; Australian Council for Safety and Quality in Health Care, 2005).

Thirteen per cent of those surveyed by HQCA in 2010 had a serious complaint about health care services received in the past year in Alberta. This result meets the 2009/2010 target of 13 per cent.

Incidence of serious complaints

	2003	2004	2006	2008	2010	Target 2009/2010
Incidence of serious complaints: percentage of Albertans reporting a serious complaint about any health care services personally received in the past year in Alberta	15%	15%	14%	13%	13%	**13%**

Source: Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2003, 2004, 2006, 2008). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

References: Health Quality Council of Alberta. Patient Concerns/Complaints Resolution: Provincial Framework April 2007. http://www.hqca.ca/phpBB2/files/hqca_concerns_framework_2007_157.pdf

Australian Council for Safety and Quality in Health Care. *Complaints Management Handbook for Health Care Services. 2005.* http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/503E44DFCCCB83BCCA2571BF00815FF5/$File/complntrmgmthbk.pdf

Goal 3: Healthy people in healthy communities

Linked to Core Business 2 — Promote and support healthy living and wellness

The health of Albertans is affected by lifestyle behaviours, employment status, education, environment, early childhood development and genetic factors. The actions and choices that people make in their daily lives and the decisions made by business leaders, industries and communities play a large role in creating a healthy society. The ministry will form broad-based alliances and partnerships with community agencies, industry, other ministries, health service providers and Alberta Health Services to build healthy communities and to support healthy choices.

Achievements

Strategy 3.1 **Provide Albertans with health information to support their health, including development of strategies and plans for a province-wide online patient health portal.**

- The first phase, requirements gathering and definition, of the provincial Personal Health Portal (PHP) was completed. The PHP will provide personalized access to trusted and Alberta specific health information online.

Strategy 3.2 **Promote wellness and childhood resiliency, ensuring alignment with multi-sectoral initiatives.**

- Out of Alberta's 62 school jurisdictions, 23 have developed school district nutrition policies or administrative regulations and 19 are in the process of developing policy or administrative regulations.
- Through the Community ChooseWell program, a record 162 communities established programs to encourage residents to increase their level of activity and eat healthier. Twenty-six communities were honoured as high achievers for going the extra mile to promote healthy living to their residents.
- Through the Healthy School Community Award program, 10 awards were presented to individuals (four awards) and organizations (six awards) for programs addressing healthy eating, physical activity and mental well-being in school communities.
- A new Premier's Award program was established — the *Alberta Food for Health Awards* — to recognize food producers, processors, and researchers for their work in creating healthy foods for Albertans. The four winners for 2009 were:
  - Diamond Willow Organic Beef from Pincher Creek for Organic Ground Beef;
  - Spragg's Meat Shop in Rosemary for English Bacon;
  - Prairie Mill Bread Company in Calgary for Honey Whole Wheat Bread; and
  - Dr. Temelli and Dr. Vasanthan from the University of Alberta for "Cereal Beta-Glucans: from Production to Health."

Strategy 3.3 **Develop strategies and policies for enhancing health and safety and for reducing the risk of disease and injury, including working with government departments and agencies.**

- A universal H1N1 influenza immunization program was developed and implemented in the fall of 2009. As a result, 36 per cent of Albertans were immunized with the H1N1 influenza vaccine.

Strategy 3.4 **Increase the engagement of government, community, stakeholders and employers in initiatives to prevent and reduce the harm associated with substance use and gambling.**

- Through the Safe Communities Initiative, 51 addiction and mental health beds were added at the Centennial Centre for Mental Health and Brain Injury (25 beds), Peter Lougheed Centre (6 beds), Poundmaker's Lodge (10 beds) and Shunda Creek (10 beds). These beds are part of the continuum of care for individuals with addiction and mental health issues and will make treatment services more widely available across the province.

Strategy 3.1 **Realign the delivery of provincial public health programs between the ministry and Alberta Health Services.**

- Service delivery components of the Sexually Transmitted Infections and Tuberculosis Control programs, and associated staff, transitioned from Alberta Health and Wellness to Alberta Health Services (AHS) on April 1, 2010. Services to Albertans related to the prevention, treatment and control of sexually transmitted infections and tuberculosis are now fully coordinated and delivered across the province by AHS.
- Provincial pandemic planning was realigned between the department and AHS so that overriding policy decisions will be developed by the department, while operational decisions will be made by AHS.

Key Performance Measures and Results

Measure 3.A **Self reported health status**

Self reported health is an indicator of overall health status which compares a person's health to other persons in his or her age group. This measure refers to a person's health in general — not only the absence of disease or injury, but also physical, mental and social well being. It is accepted across Canada as an indicator of population health.

In 2010, 88 per cent of Albertans age 18 to 64 years, as well as 88 per cent of Albertans age 65 years and over, reported that their health was excellent, very good or good. While the target of 90 per cent was not met for the 18 to 64 age group, the target of 85 per cent was exceeded among Alberta's seniors age 65 and over.

Self reported health status: percentage of Albertans reporting "excellent", "very good" or "good" health

	2006	2007	2008	2009	2010	Target 2009/2010
(1) 18 to 64 years	88%	87%	88%	89%	88%	**90%**
(2) 65 years and over	86%	78%	84%	84%	88%	**85%**

Source: Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2006, 2007, 2008, 2009). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

Measure 3.B

Healthy weight

Chronic diseases such as cardiovascular disease, cancer and diabetes are the leading causes of morbidity and mortality in Alberta. Many chronic diseases are associated with overweight and obesity. For example, persons who are overweight or obese are at risk for high blood pressure, Type 2 diabetes, coronary artery disease, stroke, respiratory problems and some cancers. Having a Body Mass Index (BMI) that falls into a normal range is associated with the least amount of health risk.

There has been no significant change over the past five years in the percentage of adult Albertans with an "acceptable" body mass index. The Government of Alberta is currently developing a Provincial Healthy Weight Strategy focused on children and youth. Alberta Health Services' *Health Promotion, Disease and Injury Prevention Strategic Action Plan 2010 – 2012 and Beyond* will contain overweight and obesity initiatives that will align with the government's strategy. In addition, Alberta Health Services is developing a province-wide strategy focused on the prevention and management of obesity for Albertans.

Healthy weight: percentage of Albertans age 18 and over with an "acceptable" body mass index

	2003	2005	2007	2008	2009	Target 2009/2010
Healthy weight: percentage of Albertans age 18 and over with an "acceptable" body mass index (BMIs 18.5 to 24.9)	47%	46%	45%	45%	42%	**47%**

Source: Statistics Canada. Canadian Community Health Survey (CCHS), Alberta Share file (2003, 2005, 2007, 2008, 2009).

Measure 3.C

Influenza immunization

Influenza has a significant seasonal impact on the health of Albertans and tends to be most severe among older Albertans, residents of long term care facilities, young infants, and those with certain chronic conditions. Hospitalizations for influenza are more likely in these populations, and cases can quickly fill acute care hospitals and emergency departments.

Alberta Health and Wellness introduced a universal influenza immunization program in the fall of 2009 in order to improve immunization rates for high risk groups. For seniors aged 65 years and over, the 2009/2010 result of 55 per cent did not meet the target of 75 per cent. A drop in the immunization rate among seniors in previous years may be due to the vaccine arriving later in the season than in the past. A further drop in 2009/2010 may reflect that the priority for the population was to be immunized against the H1N1 virus.

For children, different methods of data calculations done by each zone in Alberta Health Services (AHS) — based on receipt of one or two doses of the vaccine — for children up to 24 months of age could account for the drop in the percentage of immunized children. AHS is expanding the number of health providers who would be able to assist with the universal influenza immunization program to improve access and increase convenience for Albertans.

Influenza immunization: Percentage who have received the recommended annual influenza immunization

	2005/ 2006	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	Target 2009/2010
(1) Seniors aged 65 and over	68%	62%	60%	58%	55%	**75%**
(2) Children aged 6 to 23 months	59%	52%	64%	43%	—	**75%**

Source: Alberta Health Services; Alberta Health and Wellness, Community and Population Health Division, Interactive Health Data Application Population Estimates.

Note: Data for reporting on seasonal influenza immunization of children aged 6 to 23 months was not collected by Alberta Health Services in 2009/2010, and so results are not available for this age group.

Results for 2007/2008 are restated so as to correct an error in the Ministry 2008/2009 Annual Report on influenza immunization rates of seniors aged 65 years and over, and children aged 6 to 23 months, in 2007/2008.

Measure 3.D

Smoking

Smoking is a risk factor for lung cancer, heart disease, stroke, chronic respiratory disease, and other conditions. Tobacco use is responsible for substantial economic costs to the province in terms of health-care expenditures, and is the leading preventable cause of illness, disability and premature death in Alberta.

Among youth age 12 to 19 years, the prevalence of smoking was 13 per cent in 2009, resulting in the target of 10 per cent not being met. The result for 2009 is not statistically different from the previous period.

In contrast, a trend toward decreased smoking among 20 – 24 year olds is noted. Results from the 2009 Canadian Community Health Survey (CCHS) indicate that 25 per cent of Albertans in this age group are current (daily or occasional) smokers, surpassing the 2009/2010 target of 29 per cent.

The prevalence of smoking among these age groups is an important indicator for measuring the success of the Alberta Tobacco Reduction Strategy (ATRS), which was introduced in 2002. Coordinated and led by Alberta Health Services, the ATRS is a 10-year provincial plan to increase the wellness of Albertans and decrease health-care costs and other costs related to tobacco use. The ATRS is comprised of three pillars: prevention, cessation, and protection.

Smoking: prevalence of smoking among Alberta youth and young adults

	2003	2005	2007	2008	2009	Target 2009/2010
Prevalence of smoking (1) Alberta youth 12 to 19 years	14%	11%	12%	11%	13%	**10%**
(2) Young adults 20 to 24 years	37%	33%	30%	26%	25%	**29%**

Source: Statistics Canada. Canadian Community Health Survey (CCHS) (2003, 2005, 2007, 2008, 2009).

MEASURE 3.E

Regular, heavy drinking

Over the past decade, alcohol consumption has increased in Canada and in Alberta. Regular heavy drinking has increased, as has the consumption of alcohol by young people and the incidence of binge drinking (or drinking to intoxication). These trends pose serious concerns because alcohol-related harm tends to increase as consumption levels rise. As well, people who start drinking at an early age are more likely to be harmed by alcohol than those who do not drink until they are older.

Alberta Health Services and the Alberta Gaming and Liquor Commission drafted an Alberta Alcohol Strategy in 2008. Recently, this strategy has been approved by the Minister of Health and Wellness. As per the strategy, one aim is to develop a culture of moderation by establishing a common understanding of what constitutes sensible drinking. An expected outcome of the strategy is to reduce intoxication, heavy drinking and other risky patterns of alcohol use.

According to the 2009 Canadian Community Health Survey, 40 per cent of young Albertans age 15 to 29 years consumed five or more alcoholic drinks on one occasion, 12 or more times in the past year. This finding is not statistically different from previous periods.

Prevalence of regular, heavy drinking among young Albertans

	2003	2005	2007	2008	2009	Target 2009/2010
Prevalence of regular, heavy drinking among young Albertans	38%	38%	40%	40%	40%	30%

Source: Statistics Canada. Canadian Community Health Survey (CCHS) (2003, 2005, 2007, 2008, 2009).

Regular, heavy drinking is defined as the consumption of five or more alcoholic drinks on one occasion, 12 or more times a year for Albertans 15 to 29 years of age.

Note: It is not possible to compare the 2009 result for this measure to the 2009/2010 performance target as the target was based on historical results that were not adjusted to exclude non-response categories. Since 2009, Statistics Canada methodology for calculating rates based on Canadian Community Health Survey (CCHS) data exclude non-response categories ('refusal', 'don't know', and 'not stated') in the denominator. All figures in this table have been restated. The result for 2009 is not statistically different from previous periods.

Goal 4: Strong public health capacity to mitigate risk and enhance population health Linked to Core Business 2 — Promote and support healthy living and wellness

Risks to the public's health need to be monitored and managed to promote the health of the population and protect the health of the general public. In order to achieve this objective, it is necessary to ensure a strong public health capacity in the province. Public health involves surveillance and monitoring of communicable diseases, sexually transmitted infections (STIs) and blood-borne pathogens, developing immunization policies, ensuring food safety, preparing for pandemic responses, environmental health, community health, and infection prevention and control. Albertans can be assured that their communities remain safe and their health is supported through promotion, protection and prevention services and information to help Albertans make wise choices about their health, wellness and quality of life.

Achievements

Strategy 4.1 **Strengthen the health system's capacity to prevent, prepare and respond to public health risks.**

- Immunizations for influenza were expanded so that all Albertans aged six months and older are now eligible for a free seasonal influenza vaccine.
- The department coordinated the health sector response to the emergence of pandemic H1N1 influenza in the spring of 2009 and to a second wave that occurred in the fall. The response provided over 46,000 prescriptions for antiviral drugs and immunized over 1.3 million Albertans. The health sector also coordinated the planning and provided significant guidance for key sectors in Alberta including schools and childcare, post secondary institutions, aboriginal communities and vulnerable populations such as seniors and the homeless.
- The *Communicable Diseases Regulation* was amended to provide for better operationalization of the department's immunization policy, and to enhance the prevention, treatment and monitoring of communicable diseases.

- A majority of the sections contained in the *Human Tissue and Organ Donation Act* were proclaimed in August 2009. This new statute updated Alberta's law to be consistent with new technologies and protocols, prohibited the sale or donation of human organs or tissues for profit; improved patient safety, established independent assessment committees to protect minors and vulnerable potential donors; clarified consent provisions; and mandated physicians to consider organ donation upon the death of a patient.
- A number of *Alberta's Top Doc* videos were produced as an innovative approach for the Chief Medical Officer of Health to speak to Albertans and improve public awareness of health promotion, disease prevention and immunization.

Strategy 4.2 **Direct the Health Quality Council of Alberta to develop a plan to implement a Patient Safety Framework in collaboration with Alberta Health Services.**

- The department drafted a preliminary version of the Patient Safety Framework. The Health Quality Council of Alberta further developed the framework in collaboration with Alberta Health Services, professional regulatory bodies, the Alberta Medical Association, a patient advocate and Alberta Health and Wellness.

Strategy 4.3 **Develop a strategy for a provincial adverse event reporting system.**

- The department conducted a scan of medical adverse event reporting systems, pilot projects, and best practices from jurisdictions within Canada and abroad. Results from this information and knowledge will serve as part of the foundation for Alberta's medical adverse events reporting system.

Key Performance Measures and Results

Measure 4.A **Sexually transmitted infection — Syphilis**

Sexually transmitted infections are an important focus for public health surveillance. The diseases resulting from these infections are widespread, have potentially severe or even lethal effects, and carry high social and economic costs. Through a grant from Alberta Health and Wellness, Alberta Health Services (AHS) works with representatives of community organizations to implement targeted initiatives for high-risk populations. Enhanced prenatal syphilis screening began in May 2009. All pregnant women with positive syphilis results are monitored by Public Health, which works closely with physicians/clinics to ensure appropriate follow-up and treatment. AHS delivered targeted awareness campaigns in the initial outbreak areas of Edmonton, Calgary and Fort McMurray. In January 2009, posters and physician materials were distributed to over 5,000 physician offices, health centres and clinics. A website was launched to provide factual information on syphilis, a risk assessment quiz, how to prevent syphilis and information on where to go for testing.

The 2009 result for this measure does not meet the 2009/2010 target. Since 2005, the rate of syphilis in Alberta has been increasing. Currently, the rate of syphilis is higher than the national rate and is increasing at a greater rate.

Alberta Health and Wellness continues to work with public health officials at AHS, with not for profit organizations, and with those in other jurisdictions to prevent the spread of syphilis, provide appropriate treatment and track close contacts of all reported cases to identify and treat those affected.

As part of the provincial syphilis prevention activities, AHS will continue with targeted initiatives for those at greatest risk. AHS will also provide education messages for the general public to raise awareness about syphilis and ways individuals can protect themselves. A team (13 new staff) of prevention coordinators will work with communities and schools on prevention of sexually transmitted infections, including syphilis.

Sexually transmitted infection: Syphilis. Rate of newly reported infections (per 100,000 population)

	2005	2006	2007	2008	2009	Target 2009/2010
Syphilis: Rate of newly reported infections (per 100,000 population)	4.5	6.6	7.3	7.0	7.4	**6.5**

Source: Alberta Health and Wellness. Communicable Disease Reporting System — Sexually Transmitted Infection.

MEASURE 4.B

Patient safety

A key strategy in 2009/2010 was to direct the Health Quality Council of Alberta (HQCA) to develop a plan to implement a Patient Safety Framework in collaboration with Alberta Health Services. The Patient Safety Framework was drafted by Alberta Health and Wellness and was then transitioned to the HQCA for further development through collaboration between Alberta Health Services, selected professional regulatory bodies, and Alberta Health and Wellness.

The Patient Safety Framework aims to guide, direct and support the continuous and measurable improvement of patient safety in Alberta. The framework provides organizations and individuals providing health services with a comprehensive and systems-based approach to the provision of safe care based on fundamental principles of patient safety which will remain relevant as the healthcare system continuously evolves.

A 2010 HQCA survey of Albertans found that 9 per cent reported unexpected harm to self or an immediate family member while receiving care in Alberta within the past year. This result exceeds the 2009/2010 target of 11 per cent, and is an improved outcome compared to prior years.

Patient safety: percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year

	2003	2004	2006	2008	2010	Target 2009/2010
Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year	14%	13%	13%	10%	9%	**11%**

Source: Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2003, 2004, 2006, 2008). Health Quality Council of Alberta Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

MEASURE 4.C

Confidence in the public health system

Listening and responding to Albertans to continuously improve the quality and safety of Alberta's health system is the mission of the Health Quality Council of Alberta (HQCA). This mission is realized through the HQCA's legislated mandate to survey Albertans on their experiences with the health system. The information is vital in identifying Albertans' views and perceptions about the quality, safety and performance of the publicly funded health care system. It informs stakeholders (AHS, AHW and health professionals) responsible for health care service delivery about Albertans' experiences with the services received and the impact of those experiences on public confidence with the health system.

A HQCA 2010 survey of Albertans found that 61 per cent were satisfied with health care services personally received in Alberta within the past year, exceeding the 2009/2010 target of 60 per cent.

Confidence in the public health system: percentage of Albertans satisfied with health care services personally received in Alberta within the past year

	2004	2006	2008	2010	Target 2009/2010
Confidence in the public health system: percentage of Albertans satisfied with health care services personally received in Alberta within the past year	52%	58%	60%	61%	**60%**

Source: Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2004, 2006, 2008). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

Goal 5: Enhance health workforce collaboration, development and capacity

Linked to Core Business 3 — Enhance health service access, quality and performance

The ministry leads the development of a quality and integrated health workforce equipped to work in team-based environments, with the right skills, competencies, and technologies required to effectively resource a dynamic and ever changing health care system. Recruitment, retention and ongoing training of highly-skilled health care providers, utilized and deployed in the appropriate manner, will ensure we have the capacity to meet the needs of the population into the future.

Achievements

Strategy 5.1 **Develop policies and practices to achieve clinical and workforce objectives using the best evidence possible.**

- Two new Primary Care Networks (PCNs) were launched in 2009/2010. In July 2009, the Alberta Heartland PCN was launched in the City of Fort Saskatchewan and surrounding areas, and in January 2010 the McLeod River PCN was launched in the City of Edson. As of March 31, 2010 there were 32 PCNs operating in the province, which included more than 1,900 family physicians providing primary health care to over 2.2 million Albertans.
- More family physicians have enrolled in the Access Improvement Measures (AIM) program, which teaches physicians and teams on how to reduce wait times for patient visits. The program has also expanded to include specialists. Currently, 687 general practitioners, 65 per cent of PCNs, 291 specialists and 524 allied health providers have participated in AIM, providing improved access to health care for more than 300,000 Albertans. Over 100 physicians reduced their wait times by 48 per cent and 33 reduced their average wait times from 30 days to less than three days, a 90 per cent improvement.

Strategy 5.2 **Develop and implement strategies to ensure that Alberta has a health workforce that meets its health system's needs: including ensuring that there is an appropriately regulated adequate supply of health care workers with the right skills and competencies.**

- On April 1, 2009, midwifery services became publicly funded, which is expected to increase the number of midwives practising in Alberta and provide greater access to midwifery services. Expectant mothers across the province now have access to innovative, publicly funded midwifery services in a variety of locations including hospitals, community birth centers and in their homes.
- Two new regulations were added under the *Health Professions Act* (HPA); the *Physicians, Surgeons and Osteopaths Regulation*, and the *Respiratory Therapists Profession Regulation*. The HPA governs all regulated health professions and protects the public by helping to ensure competent, ethical professionals practice health care in Alberta.

- The Alberta International Medical Graduate program received 299 applications, assessed 189 qualified candidates, and matched 41 successful candidates to medical residency training positions in Alberta. This program increases the number of international medical graduates completing medical residency training in Alberta, which ultimately increases the number of physicians practising in Alberta.
- The Aboriginal Health Careers Bursary program provided financial assistance to 84 First Nations and Métis students to encourage them to continue their studies in a health-related degree or diploma program at a university, college or technical institute. The award amounts ranged from $1,000 to $11,000 per student.

Strategy 5.3 **Develop and maintain compensation models and a fair labour relations environment to support effective and efficient ways to offer health services.**

- During 2009/2010, one additional Clinical Alternate Relationship Plan (ARP) was implemented bringing the total number of clinical ARPs in Alberta to 43 and involving approximately 700 physicians. ARPs are funding models developed as alternatives to fee-for-service that encourage innovation in health service delivery. They are intended to enhance the recruitment and retention of health care providers, encourage interdisciplinary team-based approaches to service delivery, improve access to care and increase patient satisfaction and value for money.
- During 2009/2010, one additional Academic Alternate Relationship Plan (AARP) was implemented in the Department of Family Medicine at the University of Calgary. This brings the total number of AARPs in Alberta to nine, involving 10 academic programs, and approximately 700 physicians, primarily specialists working in either Calgary or Edmonton. AARPs support academic physicians to fulfill their four-fold mandate: clinical service delivery, administration and leadership, education and research. AARPs have been successful in implementing innovation, enhancing the recruitment and retention of health care providers, and improving access to care.
- The Rural Remote Northern Program, which is a component of the Clinical Stabilization Initiative aims to recruit/retain physicians in under-serviced areas in Alberta by providing increasing compensation based on the communities' relative isolation. The program has been successful in recruiting/retaining approximately 900 physicians (Flat Fee) and approximately 1,900 physicians (Variable Fee Premium) to under-serviced communities and improving access to care.
- The first phase of the Performance Diligence Indicator (PDI) program was successfully implemented. The program supports provincial implementation of performance-based incentives for family physicians. Just under 1,400 family physicians have participated in the program.

Strategy 5.4 **Continue to develop and expand innovative service delivery models that promote a patient-centric approach to health service delivery.**

- A comprehensive compensation strategy for health care providers continues to be developed. The strategy is intended to optimize team care and effective use of scopes of practice. A review of the current state of compensation for all health providers has been completed along with the development of performance-based principles for all health care providers, compensation principles for physicians, and the development of primary health care and academic medicine strategies.
- As of April 1, 2009 a new health care service was introduced to the Schedule of Medical Benefits to formalize the process of creating a comprehensive annual care plan for patients with multiple co-morbidities. It compensates physicians for the time and effort involved in the development, documentation and administration of care plans and coordination involved in management of the complex patients. About 84,000 Albertans with complex chronic conditions had benefited from this service in 2009/2010.

Strategy 5.5 **Conduct a pilot project with pharmacies on new reimbursement models and complete an evaluation.**

- A pilot project has been conducted to assess the impact of providing enhanced pharmacy services and paying for these services. The final report of this pilot was received in April 2010 and has been reviewed by Alberta Health and Wellness and shared with stakeholders. A pharmacy services model is being developed to support pharmacies in their expanded role of counseling and advising patients. Part of this transition includes a 3 year allowance in addition to the normal dispensing fees.

Strategy 5.6 **Enhance capacity for training health care workers and improve and modernize training and education programs.**

- As part of the Rural Integrated Community Clerkship program, 29 medical students spent eight months in 14 of Alberta's rural communities as part of their clinical training in general rural medical practices. The program is an undergraduate medical education initiative that promotes rural and generalist practice. The program provides clinical education experience supported by structured learning components delivered through in-person sessions and a web-based, distance learning environment.
- Training and education rotations of Community Medicine Residents were supported by the Chief Medical Officer of Health, which will build public health capacity and foster future public health leaders.

Key Performance Measure and Result

MEASURE 5.A **Access to primary care through Primary Care Networks**

Since the signing of the Tri-lateral Master Agreement between Alberta Health and Wellness, Alberta Health Services and the Alberta Medical Association in 2003, Primary Care Networks (PCNs) are a key strategy to support implementation of primary health care services in Alberta. PCNs are the only province-wide, comprehensive, primary health care service delivery model. Albertans enrolled within PCNs have access to multi-disciplinary, integrated and coordinated care.

Access to primary care through Primary Care Networks

	2008/ 2009	2009/ 2010	Target 2009/2010
Access to primary care through Primary Care Networks: percentage of Albertans enrolled in a Primary Care Network	55%	—	55%

Source: Alberta Health and Wellness. Primary Care Claims Assessment System (CLASS) (numerator); Alberta Health Care Insurance Plan (AHCIP) registration data (denominator).
Note: Results for 2009/2010 are not available as of August 26, 2010.

Goal 6: Increase access through effective service delivery

Linked to Core Business 3 — Enhance health service access, quality and performance

Effective service delivery involves increased access, improved service quality and improved outcomes from services provided. Through ongoing evaluations of current practice and consideration of new models and innovations, the health system can be transformed to serve Albertans better.

Achievements

Strategy 6.1 **Implement a nursing workforce efficiency review to optimize workflow practices in the health system.**

- A nursing workforce efficiency review is currently underway and is part of the Workforce Transformation Initiative. The initiative involves increasing efficiencies in service delivery through assessing, aligning and optimizing nursing roles, and redesigning, building and implementing integrated plans of care for patients and families.

Strategy 6.2 **Implement the Continuing Care Strategy including alternate financing approaches which will provide Albertans more options and choices to receive health services to "age in place."**

- As part of the Continuing Care Strategy, the Alberta government announced that 618 new supportive living and lodge spaces will be created and 86 existing spaces will be upgraded.
- The department provided funding to the Alberta Disabilities Forum to implement a province-wide demonstration project on respite care and care-giver support. The project identified the respite needs of primary caregivers of persons with disabilities across a number of disability groups and provided recommendations regarding the development of a provincial caregiver respite care program.

Strategy 6.3 **Support clients in accessing and navigating the health system through the development and implementation of a patient navigator model.**

- The department provided funding to McMaster University to develop training materials for health system patient navigation/case-management. Education workshops on case-management principles and guidelines were held across Alberta for continuing care health service providers.

Strategy 6.4 **Implement targeted strategies to improve access to health services.**

- Three new primary stroke centres were established as part of the Alberta Provincial Stroke Strategy, bringing the total to 14 primary stroke centres throughout the province. These new centres have improved Alberta's 24-hour access via telestroke technology, to optimal stroke treatment. A new province-wide Transient Ischemic Attack (TIA) Hotline was launched to provide physicians with immediate consultation and referral to stroke experts for patients showing warning signs of a stroke.
- Government announced an $18 million commitment to improve access to the emergency department at the Stollery Children's Hospital. This commitment will allow for the separation and expansion of the Stollery and University of Alberta emergency departments, increasing paediatric patient treatment access and capacity.
- An automated solution to assist in calculating and issuing payments for the Rural Remote Northern Program was successfully implemented in March 2010. The aim of the program is to retain and recruit physicians in under-serviced communities and increase citizens' access to quality care.

Strategy 6.5 **Provide provincial coordination for the integration of delivery of mental health and addictions services.**

- Four communities will see a total of 51 new mental health and addiction treatment beds open to help treat those struggling with alcoholism, drug addiction, and psychiatric conditions. These beds will be integrated with existing mental health and addiction services to expand the continuum of care.
- The *Mental Health Amendment Act* was fully proclaimed on January 1, 2010. Amendments include broadening the criteria for involuntary admission to allow for earlier intervention and treatment; requiring the provision of a discharge summary and recommendations for ongoing treatment be sent to the individual's family physician, if one is known; and introducing community treatment orders, which will encourage individuals to maintain mental health treatment while in the community. As well, the *Mental Health Patient Advocate Regulation* was amended to include the ability to investigate complaints when individuals are detained under one admission certificate or if they are under a community treatment order.

- As part of the department's commitment to the continued implementation of the Safe Communities Initiative:
  - $11.8 million was provided to expand the Provincial Diversion and Family Violence Treatment program to six new communities and to broaden addiction prevention efforts for youth and young adults. The programs support increased access to addiction and mental health services and range from prevention to treatment initiatives.
  - The Immigrant and Refugee Youth Mental Health project was implemented. This project supports families and communities to address mental health challenges, build the capacity, skills and confidence of youth and their families and communities, promotes the use and maintenance of newcomers' home languages, and supports healthy intergenerational and family relationships. These support services are intended to reduce the likelihood of immigrants and refugees becoming involved in gangs and other criminal activities
- The *Protection of Children Abusing Drugs Amendment Act* received Royal Assent on May 26, 2009 and is awaiting proclamation. The Act increases the duration of the confinement period to provide more stabilization services; strengthens the review hearing process and addresses transportation issues.

Key Performance Measures and Results

Measure 6.A

6.a.1 Wait time for heart surgery (coronary artery bypass graft) — 90th percentile wait time in weeks, by urgency level

The Government of Alberta has made a significant commitment of capital funding to build or expand cardiac service capacity, including the opening of the Mazankowski Alberta Heart Institute in Edmonton in July 2009.

Wait times for coronary artery bypass graft (CABG) surgery are shown by urgency level. In 2009/2010, 90 per cent of patients with the most urgent need for CABG surgery waited two weeks or less for this surgery, meeting the provincial target of two weeks. As in 2008/2009, it is not possible to verify if the targets for Urgency Level II and Urgency Level III CABG surgery were met in 2009/2010, due to inconsistencies in coding practices between the Edmonton and Calgary cardiac surgery sites in classifying patients waiting for CABG surgery as Urgency Level II or Urgency Level III.

It should be noted that Alberta Health Services is in the early stages of integrating information from former health regions and is working collaboratively to implement standard approaches to measurement and ensure more consistent provincial data capturing and reporting.

Wait time for heart surgery (CABG) by urgency level: 90th percentile wait time in weeks

	2005/ 2006	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	Target 2009/2010
Heart surgery (CABG) Urgency Level I	7	4	2	2	2	**2 weeks**
Urgency Level II	14	18	14	20	21	**6 weeks**
Urgency Level III	23	34	26	18	17	**26 weeks**

Source: Alberta Health and Wellness, Alberta Waitlist Registry.

Note: Results are restated for all prior years due to changes in methodology. Calculation of results is now based on data for the entire fiscal year, not data 90 days prior to the last day of March.

6.a.2 Wait time for hip replacement surgery; 6.a.3 Wait time for knee replacement surgery

In 2009/2010, 90 per cent of patients who needed hip replacement surgery waited 35 weeks or less. As a result, the 2009/2010 target of 26 weeks for hip replacement surgery was not met. For 90 per cent of patients waiting for knee replacement surgery in 2009/2010, the wait time was 49 weeks, up from 46 weeks in 2008/2009, and significantly longer than the target wait time of 26 weeks.

On February 16, 2010, Alberta Health and Wellness and Alberta Health Services announced a six week plan through March 31, 2010 to immediately increase the number of surgeries in high-priority areas, including hip replacement and knee replacement surgery, so as to reduce wait times for these surgeries.

The Government of Alberta has made a significant commitment of capital funding to build or expand additional orthopaedic capacity in Edmonton. One major expansion project is a new orthopedic surgical facility in Edmonton that is planned to open in 2010/2011.

Wait time for hip replacement and knee replacement surgery: 90th percentile wait time in weeks

	2005/ 2006	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	Target 2009/2010
Hip replacement surgery	51	43	36	36	35	**26 weeks**
Knee replacement surgery	63	53	49	46	49	**26 weeks**

Source: Alberta Health and Wellness, Alberta Waitlist Registry.

Note: Results are restated for all prior years due to changes in methodology. Calculation of results is now based on data for the entire fiscal year, not data 90 days prior to the last day of March.

6.a.4 Wait time for children's mental health services

According to the National Institute of Mental Health, nearly one half of mental illnesses begin by age 14. While some children get seen immediately, especially those in crisis, there are still children who wait longer than they should. Providing reasonable access to needed health services is a major objective and a defining attribute of the publicly funded health system. Longer waits affect health status and quality of life and result in more costly health services.

The 2004 Provincial Mental Health Plan indicates that children and adolescents are priority populations for mental health service enhancements and children's mental health is one of six priority access areas in Alberta. The Postl report (*Final Report of The Federal Advisor on Wait times — Health Canada, 2006*) suggests that Federal, Provincial and Territorial governments should address children's wait times due to the fact that the issues they face in their youth as they develop may have an effect on their lifetime health.

In August 2008, the *Children's Mental Health Plan for Alberta: Three Year Action Plan* was released by Alberta Health and Wellness. The two goals in the Action Plan are to improve access to children's mental health services and address the mental health needs of children and youth at risk. Strategy 1.1 of Goal 1 is to implement access standards for children's mental health services for emergent care (within 24 hours), urgent care (within two weeks) and scheduled visits (within 30 days). Monitoring wait times is a key outcome measure of improving access to services.

In 2009/2010, 90 per cent of children referred for mental health services waited 10 weeks or less to receive their first contact with a mental health service provider. This result meets the 2009/2010 target, which is significant as a large organizational change occurred over the last year and included a slow down in hiring and executing grants to operate children's mental health services. In turn, with very few hires and resources, the waitlist for children in need of mental health intervention decreased from 11 weeks in 2008/2009 to 10 weeks in 2009/2010. It is important to note that these results address only those children receiving services from community mental health clinics, and do not include the wait time for children who have accessed inpatient services or visited emergency departments.

Wait time for children's mental health services: 90th percentile wait time in weeks

	2005/ 2006	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	Target 2009/2010
Wait time for children's mental health: 90th percentile wait time in weeks	10	11	10	11	10	**10 weeks**

Source: Alberta Health Services, Addictions and Mental Health (2009/2010). Community mental health clinics and intake services across Alberta including specialized programs in hospitals and services provided through CASA (2005/2006, 2006/2007, 2007/2008, 2008/2009).

Measure 6.B **Public rating of access to emergency department services**

Albertans access emergency and urgent care services in many different ways. Hospital emergency departments see the majority of patient emergencies in Alberta, and access to services has become an issue. Ensuring equitable and timely access to emergency department services is essential.

Wait times to access emergency department services may affect patients' overall experience of care in emergency departments. According to a 2010 HQCA survey of Albertans, 55 per cent who had accessed

emergency department services for themselves or a close family member rated ease of access to emergency department services as "easy" or "very easy". This result is an improvement from prior years, but did not meet the 2009/2010 target of 60 per cent.

Alberta Health and Wellness (AHW) has initiated a number of strategies to address wait times, including the Alberta Health Workforce Action Plan aimed at training, recruiting and retaining more health professional to address current and future demand for health care services. In 2009, Alberta Health Services established the Emergency Department Integration Team which has developed provincial standards for delivery of emergency department care including addressing the issue of overcrowding and long patient wait times in emergency departments.

Public rating of access to emergency department services

	2003	2004	2006	2008	2010	Target 2009/2010
Public rating of access to emergency department services: percentage rating ease of actually obtaining emergency department services needed for self as "easy"	46%	50%	48%	51%	55%	**60%**

Source: Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2003, 2004, 2006, 2008). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

Measure 6.C

Continuing care: The number of persons waiting in an acute care hospital bed for continuing care placement

Continuing care is an integrated range of services supporting the health and wellbeing of individuals living in their own home or in a supportive living or long term care setting. Continuing care clients are not defined by age, diagnosis or the length of time they may require service, but by their needs for continuing care. This year was the first year of the implementation of the Continuing Care Strategy (released in December 2008), which addressed growing demands for and concerns around continuing care services. $8.5 million was provided to Alberta Health Services (AHS) from AHW to carry out a number of initiatives that would build and strengthen community-based care while decreasing dependence on facility-based continuing care.

As of March 31, 2010, a total of 707 persons were waiting for continuing care placement while in an acute care facility. The 2009/2010 target of 505 individuals waiting for continuing care placement while in an acute care facility was not met, although there was a decrease in the number compared with results from last year.

Over the past year, AHW and AHS have been working in partnership to reduce the number of persons waiting for continuing care while in acute care through a number of strategies such as expanding home care and supportive living. However, the results indicate that the continuing care wait list reduction strategies developed at the provincial level have not yet been operationalized to the point where they have significantly

affected reductions in the waitlist. Increased emphasis on implementing these strategies and ensuring that the strategies are clearly communicated at all levels will need to take place in order to successfully meet the targets for the subsequent years.

Government is committed to expanding spaces in continuing care, and in March 2010 announced that it had raised $74.5 million for the construction of seniors' accommodations in the province. This will add capacity to the continuing care system, particularly in the supportive living stream, and reduce stress on the acute care system.

The number of persons waiting in an acute care hospital bed for continuing care placement

	2007/ 2008	2008/ 2009	2009/ 2010	Target 2009/2010
The number of persons waiting in an acute care hospital bed for continuing care placement	645	754	707	505

Source: Alberta Health and Wellness; Alberta Health Services, Health System Compliance and Accountability.

Goal 7: Improve health service efficiency and effectiveness through innovation and technology Linked to Core Business 3 — Enhance health service access, quality and performance

Alberta's health system needs to be enhanced through new approaches, adopting new innovations, incorporating new technologies, and learning from experiences in other jurisdictions for application in Alberta. It is also necessary to be prudent with existing fiscal resources by managing costs, expenses, and ensuring that health outcomes are improved. Sustainability of the health system will result from more effective and efficient use of resources, leveraging new innovations and technologies for greater impact, and collaborating with other jurisdictions on shared approaches to health services.

Achievements

Strategy 7.1 **Coordinate and lead the continued adoption of automated information systems and technology by health care providers.**

- The *Health Information Amendment Act* received Royal Assent in June 2009. The Act amends the *Health Information Act* (HIA) in several important ways, including expanding the HIA beyond the publicly-funded health system and creating a legislative framework for the Alberta Electronic Health Record, or Alberta Netcare, as well as other custodians' Electronic Health Record Information Systems. Two regulations will come into force along with the *Health Information Amendment Act*: the *Health Information Amendment Regulation* and the *Alberta Electronic Health Record Regulation.*
- An application that supports the automated payment of physicians in the Rural and Remote Northern Program was successfully developed and implemented.

Strategy 7.2

Develop a health research plan that includes strategic priorities for economic development that would transform the healthcare economy.

- In collaboration with Advanced Education and Technology, a health research and innovation plan has been developed that builds on past investments and positions Alberta to continue to be at the forefront of health research, innovation and discovery. Alberta's Health Research and Innovation Strategy aims for improved health outcomes, a more accessible and responsive health care system, and diversified opportunities for economic growth.

Strategy 7.3

Develop and promote policies and linkages with other jurisdictions for innovative initiatives.

- Under Alberta's leadership, provincial deputy ministers of health from across Canada endorsed the *National Plan for the Management of Blood Shortages*. The plan includes cooperation and distribution options that enable the provinces to respond to potential blood shortages.

Strategy 7.4

Review and recommend the introduction of further integrations of new and existing technologies to improve service and manage public costs.

- The Alberta Health Technologies Decision Process streamlined health technology assessment processes to provide the reliable evidence and information necessary to make public funding decisions on new and existing health technologies and services. The department and Alberta Health Services have developed and defined respective roles and responsibilities to make the process more responsive, robust and comprehensive.
- Four new technologies were reviewed through the Alberta Health Technologies Decision Process to provide evidence informed decisions on universal newborn hearing screening, syphilis testing using enzyme immunoassay, double balloon endoscopy/enteroscopy, and artificial cervical disc arthroplasty.
- An Integrated Information Management/Information Technology (IM/IT) Strategic Plan was developed for the 2009-2015 period. This plan sets provincial priorities and goals for provincially-funded health care IM/IT investment, provides context and framework for detailed planning by individual organizations, and provides an accountability framework for monitoring progress in executing the plan.
- A new Mental Health reporting application was successfully implemented. The application collects data on Albertans' use of mental health facilities. The data collected will enhance policy development and planning to meet future needs for mental health services.

Key Performance Measures and Results

Measure 7.A Number of care providers accessing Alberta Netcare

Alberta Netcare (Alberta's electronic health record — EHR) is a clinical information network that links community physicians, pharmacists, hospitals, and other authorized health care professionals across the province. Netcare lets health care practitioners view health information such as patient allergies, prescriptions and lab tests electronically. As more health providers access the system, more consistent and improved treatment decisions will result. The measure was introduced to ensure accuracy and relevance of data used for tracking toward deployment and uptake goals.

The growth in Netcare users in 2009/2010 is consistent with the historical trend over the last four years for user expansion. More health care system providers are qualifying for user enrollment and access to Netcare information based on their professional role within the Alberta health system. Streamlining of the Alberta Health Services (AHS) organization is facilitating easier access to Netcare by deploying through existing clinical care systems.

Number of care providers accessing Alberta Netcare

	2005/ 2006	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	Target 2009/2010
Number of care providers accessing Alberta Netcare	18,675	22,918	29,110	34,200	39,866	**29,500**

Source: Alberta Health and Wellness, Information Management Branch. Electronic Health Record (EHR) applications: Pharmaceutical Information Network (PIN); Lab Test Results History (LTRH); Person's Directory (PD); Alberta Netcare Portal 2004.

Measure 7.B Percentage of Albertans who are aware of Health Link Alberta

Health Link Alberta is a 24 hour a day, 7 day a week nurse telephone advice and health information services that is available to Albertans from anywhere in the province by dialing: Calgary 403-943-5465; Edmonton 780-408-5465; or toll-free 1-866-408-5465. Highly trained registered nurses provide advice and information about health symptoms or concerns that an individual person or a family member may be experiencing. Health Link can also assist Albertans to locate appropriate services and health information. The online health information can be viewed at HEALTHLinkAlberta.ca.

According to a 2010 HQCA Survey of Albertans, 76 per cent of Albertans are aware of Health Link Alberta, which exceeds the 2009/2010 target of 73 per cent. Among people aware of Health Link, 36 per cent said they had called this health information service in the past year, which is less than the target of 42 per cent.

Percentage of Albertans who are aware of Health Link Alberta

	2006	2007	2008	2009	2010	Target 2009/2010
Percentage of Albertans who are aware of Health Link Alberta	66%	67%	71%	71%	76%	**73%**
Percentage of Albertans who have used Health Link Alberta	39%	37%	33%	37%	36%	**42%**

Source: Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2006, 2007, 2008, 2009). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

MEASURE 7.C

Percentage of community physicians enrolled in the Physician Office System Program (POSP) and using the electronic medical record in their clinic

This performance measure quantifies the adoption rate of electronic medical record (EMR) technology into physician practices. The objective of the Physician Office System Program (POSP) is to enable the use of qualified EMRs by physicians, to improve patient care and support best practice care delivery. EMR technology supports best practice care delivery and helps community physicians provide improved primary care services to Albertans.

In 2009/2010 there were 4,820 community physicians in Alberta, of which 46 per cent (2,232) were enrolled in POSP and using an EMR in their clinic. The EMR adoption rate of 46 per cent is lower than the target of 48 per cent, due to implementation delays. The process to build EMR systems to Alberta specifications took longer to complete than anticipated, resulting in less time to implement the EMRs in physician clinics. POSP and the EMR vendors are working together to increase the capacity to implement systems, with the goal of achieving future targets.

Community physicians enrolled in the Physician Office System Program (POSP) and using the electronic medical record in their clinic

	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	Target 2009/2010
Percentage of community physicians enrolled in the Physician Office System Program (POSP) and using the electronic medical record in their clinic	42%	45%	45%	46%	**48%**

Sources: Alberta Medical Association (AMA) membership database (MSIS); POSP funding and enrolment database (iPOSP); Alberta Health Services (AHS) lab destinations per physician.

Integrated Results Analysis

This section provides a discussion of how the resources were utilized compared to the budget and the previous year.

Funding to Alberta Health Services for services such as acute care, continuing care, mental health, addiction and prevention services, public health, and cancer services was $8.1 billion. This is $342 million more than the budget and an increase of $525 million over the previous year. The $342 million shortfall is attributed primarily to one-time funding to eliminate the 2008/2009 accumulated deficit of the former health authorities. The $525 million spending increase from 2008/2009 includes an increase of 7.8 per cent in the base operating grant.

Compensating Alberta's physicians through the various funding agreements including fee-for-service payments, primary care funding, and clinical and academic alternate relationship plans, totaled $2.9 billion. This is $110 million less than the budget and an increase of $290 million over the previous year. The $110 million surplus is attributed primarily to delays in the Physician Office System Program implementation, slower growth of Primary Care Networks and slower recruitment of doctors to Academic Alternate Relationship Program than anticipated. The $290 million spending increase from 2008/2009 includes negotiated rate increases under the physician funding agreement and increased volume of physician services provided.

Total spending on programs such as supplementary health benefits, human tissue and blood services, medical resident allowances, air ambulance services, out of province health care costs, health research, aging in place strategy and safe communities' initiatives was $1.5 billion. This is $183 million less than the budget and $38 million less than the previous year. The $183 million surplus is attributed primarily to lower than anticipated utilization in programs such as air ambulance and supplementary health benefits programs, decreased funding to Alberta Health Services for information technology projects and continuing care initiatives. The $38 million spending decrease from 2008/2009 is primarily due to the elimination of the partial subsidy for chiropractic services effective July 1, 2009.

Spending to administer vaccines, excluding the H1N1 vaccine, provided to Alberta Health Services for communicable disease control, as well as funding to community agencies and other organizations to support prevention and health promotion activities and programs was $61 million. This is $29 million less than the budget and $26 million less than the previous year. The surplus from budget and the decrease from 2008/2009 are both attributed to decreased spending for children's health initiatives and the West Nile virus response.

Construction of new facilities, expansion or upgrading of existing facilities, capital maintenance for existing infrastructure, and diagnostic medical equipment for Alberta Health Services was $211 million. This is $27 million less than the budget and also $647 million less than the previous year. The surplus from budget and the spending decrease from 2008/2009 are both attributed to the reallocation of capital funds to future years to reflect updated construction schedules and related costs of health infrastructure projects. The decrease from 2008/2009 is partially offset by one-time funding of $83 million for diagnostic medical equipment.

Total spending for the operations of the department, including staffing and costs to operate and maintain information systems, was $146 million. This is $46 million less than the budget and $25 million less than the previous year. The $46 million surplus is primarily due to vacant positions, reduced contract spending as well as savings from information systems contracts due to decreased utilization of services.

In 2009/2010, an H1N1 influenza pandemic was declared. One-time expenditures of $80 million supported the provision of emergency and in-patient hospital services, physician compensation and vaccinations.

Changes to Performance Measures Information

New or Changed Performance Measures in the 2009/2010 Annual Report:

- Annual ministry operating expense: percentage change over prior year actual.
- Incidence of serious complaints: percentage of Albertans reporting a serious complaint about any health care services personally received in the past year in Alberta.
- Patient safety: percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year.
- Confidence in the public health system: percentage of Albertans satisfied with health care services personally received in Alberta within the past year.
- Access to primary care through Primary Care Networks: percentage of Albertans enrolled in a Primary Care Network.
- Public rating of access to emergency department services: percentage rating ease of actually obtaining emergency department services needed for self as "easy".
- Wait time for: Heart surgery (CABG) — Urgency Level I (More urgent); Urgency Level II (Less urgent); Urgency Level III (Elective).
- Smoking: prevalence of smoking among (1) Alberta youth 12 to 19 years; (2) young adults 20 to 24 years.
- Sexually transmitted infection: Syphilis — rate of newly reported infections (per 100,000 population).
- Continuing care: Number of persons waiting in an acute care hospital bed for continuing care placement.
- Percentage of community physicians enrolled in the Physician Office System Program (POSP) and using the electronic medical record in their clinic.

Key Performance Measures discontinued in the 2010 – 2013 Business Plan:

- Annual ministry operating expense: percentage change over prior year actual
- Healthy weight: percentage of Albertans age 18 and over with an "acceptable" body mass index (BMIs 18.5 to 24.9).

New or Changed Performance Measures in the 2010/2011 Annual Report:

- Satisfaction with health care services received: percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year.
- Influenza immunization: percentage of Albertans who have received the recommended seasonal influenza immunization: Seniors aged 65 and over; Children aged 6 to 23 months; Residents of long term care facilities.
- Sexually transmitted infections: rate of newly reported infections (per 100,000 population): chlamydia; gonorrhea; syphilis.
- Congenital syphilis: rate per 100,000 births (live and still born).
- Generic drug spending in Alberta: community dispensed percentage of generic prescription drugs in Alberta.
- Body mass index: percentage of Albertans age 18 and over who are overweight or obese.

- Continuing care: number of persons waiting in an acute care hospital bed for continuing care; number of persons waiting in the community for continuing care.
- Wait time for children's mental health services: per cent of children receiving "scheduled" mental health treatment within 30 days.
- Wait time for cataract surgery: 90th percentile wait time in weeks.
- Wait time for all other elective surgical procedures: 90th percentile wait time in weeks
- Emergency department length of stay: 90th percentile wait time in hours for (1) minor or uncomplicated cases; (2) complex cases.
- Access to primary care providers: percentage of Albertans reporting they have a personal family doctor.
- Physicians linked to Primary Care Networks: percentage of family physicians linked to Primary Care Networks.
- Physician utilization of electronic medical records: percentage of community physicians using the Electronic Medical Record in their clinic.

Performance Measures — Data Sources and Methodology

Data Sources

1.a. Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2006, 2007, 2008, 2009). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

2.a. Department of Health and Wellness audited financial statements.

2.b. Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2003, 2004, 2006, 2008). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

3.a. Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2006, 2007, 2008, 2009). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

3.b. Statistics Canada. Canadian Community Health Survey (CCHS), Alberta Share file (2003, 2005, 2007, 2008, 2009).

3.c. Alberta Health Services; Alberta Health and Wellness, Community and Population Health Division, Interactive Health Data Application Population Estimates.

3.d. Statistics Canada. Canadian Community Health Survey (CCHS) (2003, 2005, 2007, 2008, 2009). For the 12 to 19 age group, 2009 CCHS results are published by Statistics Canada in Table 105-0501 Health indicator profile, annual estimates, by age group and sex, Canada, provinces, territories, health regions (2007 boundaries) and peer group, occasional, CANSIM (database). For the 20 to 24 age group, the 2009 results are calculated using the Alberta Share File of the 2009 Canadian Community Health Survey.

3.e. Statistics Canada, Canadian Community Health Survey (CCHS) (2003, 2005, 2007, 2008, 2009).

4.a. Alberta Health and Wellness. CDRS-STI (Communicable Disease Reporting System — Sexually Transmitted Infection) database.

4.b. Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2003, 2004, 2006, 2008). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

4.c. Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2004, 2006, 2008). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

5.a. Alberta Health and Wellness. Claims Assessment System (CLASS) (numerator); Alberta Health Care Insurance Plan (AHCIP) population registration data (denominator).

6.a (1). Alberta Health and Wellness. Alberta Waitlist Registry.

6.a (2). Alberta Health and Wellness. Alberta Waitlist Registry.

6.a (3). Alberta Health and Wellness. Alberta Waitlist Registry.

6.a (4). Alberta Health Services, Addictions and Mental Health (2009/2010). Community mental health clinics and intake services across Alberta including specialized

programs in hospitals and services provided through CASA (2005/2006, 2006/2007, 2007/2008, 2008/2009).

6.b. Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2003, 2004, 2006, 2008, 2010). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

6.c. Alberta Health and Wellness; Alberta Health Services, Health System Compliance and Accountability.

7.a. Alberta Health and Wellness, Information Management Branch. Electronic Health Record (EHR) applications:

- Pharmaceutical Information Network (PIN)
- Lab Test Results History (LTRH)
- Person's Directory (PD)
- Alberta Netcare Portal 2004

7.b. Health Quality Council of Alberta. Provincial Survey — Satisfaction with Health Care Services (2006, 2007, 2008, 2009, 2010). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.

7.c. Alberta Medical Association (AMA) membership database (MSIS)
POSP funding and enrolment database (iPOSP)
Alberta Health Services (AHS) Lab destinations per physician

Methodology

Performance Measure 1.a Public rating of health system overall: percentage rating the health system as either "excellent" or "good"

This measure identifies Albertans' rating of the health care system and the quality of medical services it provides.

2006	2007	2008	2009	2010
65%	55%	60%	63%	65%

Data are collected through a telephone survey of randomly selected Alberta households. To assess public rating of the health system overall, Albertans 18 years of age and over are asked, "Thinking broadly about Alberta's health care system and the quality of medical services it provides, how would you describe it overall? Would you say it is excellent, good, fair, or poor?" The total percentage of respondents who rate the health system overall as excellent or good is calculated and reported.

In 2010, data were collected through a telephone survey of 4,341 randomly selected Alberta households. A total of 4,173 respondents answered the question on rating the health care system and the quality of medical services it provides. Results are reliable within ±1.9 per cent, 19 times out of 20.

Performance Measure 2.a Annual Ministry operating expense: percentage change over prior year actual

This measure identifies the percentage change over prior year actual in the annual Ministry operating expense. The result is calculated as the total department operating expense minus prior year department operating expense, divided by prior year department operating expense. 'Operating Expense' refers to "Total Voted and Statutory Expenses (adjusted

for Write-down of Inventory)", as stated in the department of health and wellness' audited financial statements.

Performance Measure 2.b Incidence of serious complaints: percentage of Albertans reporting a serious complaint about any health care services personally received in the past year in Alberta

This measure identifies Albertans' self-reports of serious complaints about any health care services personally received in the past year in Alberta. Data are collected through a telephone survey of randomly selected Alberta households. In 2010, data were collected through a telephone survey of 4,341 randomly selected Alberta households. A total of 3,773 respondents answered the question,

"Have you had a SERIOUS complaint about any health care services you have received in Alberta in the past year?"

The total percentaqe of respondents who responded "yes" to this question is calculated and reported. Results are reliable within ±1.4 per cent, 19 times out of 20.

Performance Measure 3.a Self reported health status: percentage of Albertans reporting "excellent", "very good" or "good" health

(1) 18 to 64 years

(2) 65 years and over

This measure identifies Albertans' self-reported health status. How people rate their own health is affected by a variety of factors including chronic disease, disability, temporary illness and mental health..

Data are collected through a telephone survey of randomly selected Alberta households. To assess self-reported health status, Albertans 18 years of age and over are asked: "In general, compared with other people your age, would you say your health is excellent, very good, good, fair, or poor?" The total percentage of respondents who rate their health as excellent, very good, or good is calculated and reported.

In 2010, data were collected through a telephone survey of 4,341 randomly selected Alberta households. Among these households, 3,727 people age 18 to 64 years responded to the question on self-reported health status. Results for this age group are reliable within ±2.0 per cent, 19 times out of 20. A total of 604 Albertans age 65 years and over responded to the question on self-reported health status. Results for this age group are reliable within ±2.8 per cent, 19 times out of 20.

Performance Measure 3.b Healthy weight: percentage of Albertans age 18 and over with an "acceptable" body mass index (BMIs 18.5 to 24.9)

The Canadian Community Health Survey (CCHS) includes a wide range of questions about the health and health behaviours of residents in each province; since 2007, it is conducted annually. The CCHS includes questions about the respondent's height and weight, from which the Body Mass Index (BMI) is calculated using the international standard. Healthy Weight refers to "Normal Weight, BMI 18.50-24.99". The survey population includes Canadians age 12 years and over. Results for Healthy Weight are for respondents aged 18 years and over only.

Respondents to the survey are asked the questions:

"The next questions are about height and weight. How tall are you without shoes on?" and "How much do you weigh?"

In 2009, the sample for Alberta was 5,152 respondents. Among those respondents, 4,390 answered the questions on height and weight. Results for this measure are reliable within ±2.5 per cent, 19 times out of 20.

Performance Measure 3.c Influenza immunization: percentage who have received the recommended annual influenza immunization

(1) Seniors aged 65 and over

(2) Children aged 6 to 23 months

The numerator data (count of those immunized by age category) are manually collected and aggregated by Alberta Health Services zones and sent centrally for inclusion into AHW report form. The denominator data are retrieved from Alberta Health and Wellness' (AHW) Interactive Health Data Application Population Estimates which is based on mid-year (June 30) registration population estimates.

In order to calculate the result for this measure, an AHW template is manually completed by Public Health in AHS and electronically emailed to the Community Health Branch in AHW. The data are then input into an Excel spreadsheet to determine the provincial rate for each cohort.

For this measure, seniors include all persons 65 years and older in Alberta.

Children include those aged six to 23 months during the influenza season.

Performance Measure 3.d Smoking: prevalence of smoking

(1) Alberta youth 12 to 19 years

(2) Young adults 20 to 24 years

This measure is defined as the percentage of Alberta youth 12 to 19 years, and young adults 20 to 24 years, who report that they smoke daily or occasionally.

The Canadian Community Health Survey (CCHS) includes a wide range of questions about the health and health behaviours of residents in each province; since 2007, it is conducted annually. The CCHS includes questions about the respondent's smoking habits, including the question, "At the present time, do you smoke cigarettes daily, occasionally or not at all?" Respondents who indicate they smoke cigarettes on a daily basis are coded as "daily smokers". Respondents who state that they smoke cigarettes occasionally at the present time are coded as occasional smokers. Coded also as "occasional smokers" are former daily smokers who currently smoke occasionally, current smokers who have never smoked on a daily basis, and current smokers who have smoked less than 100 cigarettes in their lifetime.

Responses to the CCHS questions on smoking are used to create a derived variable "SMKDSTY" which indicates the type of smoker the respondent is, based on his/her smoking habits. Types of smoker include "daily smoker", "occasional smoker" (former daily smoker), occasional smoker (never a daily smoker or has smoked less than 100 cigarettes lifetime), former daily smoker (non-smoker now), former occasional smoker (at least 1 whole cigarette, non-smoker now), and never smoker (a whole cigarette). The derived variable SMKDSTY (type of smoker) is analyzed by the age group of survey respondents to obtain the results reported on the prevalence of smoking by age group.

For results among Alberta youth 12 to 19 years: Among those respondents, an estimated 674 people from Alberta aged 12-19 answered the questions on smoking. Results are reliable within ± 4 per cent, 19 times out of 20.

For results among young adults 20 to 24 years: Results on the prevalence of smoking among young adults age 20 to 24 years are a new response category for this measure, and are included in the ministry Annual Report for the first time in 2009/2010. A total of 329 people aged 20-24 answered the questions on smoking. Results are reliable within ± 7 per cent, 19 times out of 20.

Performance Measure 3.e Regular, heavy drinking: prevalence of regular, heavy drinking among young Albertans

This measure identifies the prevalence of regular, heavy drinking among young Albertans. Regular, heavy drinking is defined as the consumption of five or more alcoholic drinks on one occasion, 12 or more times a year for Albertans 15 to 29 years of age.

The data source is the Canadian Community Health Survey (CCHS) which includes a wide range of questions about the health and health behaviours of residents in each province; since 2007, it is conducted annually. The CCHS includes questions about the respondent's drinking habits. The historic results (2003, 2005, 2007, and 2008) have been restated. Since 2009, Statistics Canada calculates rates from the CCHS excluding non-response categories ('refusal', 'don't know', and 'not stated') in the denominator. Performance targets are based on unadjusted percentages (notably lower).

Respondents to the survey were asked the question:

"How often in the past 12 months have you had 5 or more drinks on one occasion?"

In 2009, the sample for Alberta was 5,152 respondents. Among those respondents, 991 people aged 15 to 29 years answered the question on the frequency of drinking. Results are reliable within ±5 percent, 19 times out of 20.

Performance Measure 4.a Sexually transmitted infection: Syphilis, rate of newly reported infections (per 100,000 population)

The result of this measure is based on data from Alberta Health and Wellness' CDRS-STI (Communicable Disease Reporting System — Sexually Transmitted Infection) database, which provides the number of newly reported cases of syphilis in a given calendar year, and the Alberta Health and Wellness' Business Intelligence Environment, which provides the mid-year population.

The rate of newly reported syphilis infections is calculated as:

$$\text{Syphilis rate} = \frac{(\text{Number of newly reported cases in given calendar year})}{\text{Mid-year population of given calendar year}) * 100{,}000}$$

Performance Measure 4.b Patient safety: percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year

The result for this measure is based on the results of the Health Quality Council of Alberta survey: *Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.* This measure is defined as the percentage of respondents who responded "yes" to the question:

"To the best of your knowledge, have you, or has a member of your immediate family experienced UNEXPECTED HARM while receiving healthcare in Alberta WITHIN THE PAST YEAR?"

In 2010, data were collected through a telephone survey of 4,341 randomly selected Alberta households. A total of 3,742 respondents answered the question on experiencing unexpected harm while receiving health care in Alberta. Results are reliable within ±1.2 per cent, 19 times out of 20.

Performance Measure 4.c Confidence in the public health system: percentage of Albertans satisfied with health care services personally received in Alberta within the past year

The result for this measure is based on the results of the Health Quality Council of Alberta survey: *Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.* This measure is defined as the total percentage of respondents who responded "satisfied" or "very satisfied" to the question:

"Thinking about all of your personal experiences within the past year with the health care services in Alberta that we just reviewed, to what degree are you satisfied or dissatisfied with the services you have received?"

In 2010, data were collected through a telephone survey of 4,341 randomly selected Alberta households. A total of 3,956 respondents answered the question on satisfaction of health care services personally received in Alberta within the past year. Results are reliable within ±2.0 per cent, 19 times out of 20.

Performance Measure 5.a Access to primary care through Primary Care Networks: percentage of Albertans enrolled in a Primary Care Network

This measure is based on the number of patients informally enrolled in a Primary Care Network (PCN). Patients are considered to be informally enrolled in a PCN when they are assigned to a physician/ nurse practitioner/ pediatrician registered to a PCN. There are 4 steps used to assign a patient to a physician:

Step 1: Patients who have seen one physician/nurse practitioner/pediatrician only are assigned to that physician/nurse practitioner/pediatrician.

Step 2: Patients who have seen more than one physician, but one physician is predominant, and then assigns the patient to that physician.

Step 3: Patients who have seen multiple physicians the same number of times are assigned to the physician who did the physical exam last.

Step 4: Patients who have seen multiple physicians the same number of times and had no physical examination done are assigned to the physician who saw the patient last.

The percentage of Albertans linked to a PCN is calculated as follows: The number of Albertans informally enrolled in a PCN according to the four cut methodology (the numerator) is divided by the number of Albertans with a valid Alberta Health Care Insurance Card (the denominator). The number of Albertans with a valid Alberta Health Care Insurance Card is derived from population registration data which is published once a year in the Alberta Health and Wellness: Alberta Health Care Insurance Plan Statistical Supplement. Information for the calculation of the four cut methodology uses physician claims payment data from the Claims Assessment System (CLASS). Individuals registered under the Alberta Health Care Insurance Plan may receive services from any physician of their choice who is eligible to submit claims to the ministry, including physicians who have agreed to participate in a Primary Care network. Individual patients are considered to be "informally enrolled" in a Primary Care Network when the physician of their choice, who has agreed to participate in a Primary Care Network, submits claims and receives payment from the ministry for primary care services provided to that patient.

Performance Measure 6.a (1) Wait time for: Heart surgery (coronary artery bypass graft)
Urgency Level I (More urgent)
Urgency Level II (Less urgent)
Urgency Level III (elective)

The result for this measure is based on the time (in weeks) within which 90 per cent of person cases were completed (had their procedure performed as planned). The calculation uses Alberta Waitlist Registry (AWR) records of persons served from April 1 to March 31 of the reporting fiscal year. It does not include persons who voluntarily delayed their procedure, or those who had a scheduled follow-up procedure, or those that received emergency surgical care.

The general definition of a percentile is a point on a rank-ordered scale, found by sorting a group of observations* in order of magnitude from lowest to highest. The first percentile approximates the very lowest/bottom number found, while the 100th percentile is the very highest reported. The nth percentile is the point exceeding n per cent of the observations. For example, a wait time equal to or greater than 90 per cent of other observations is the 90th percentile wait time.

*Each observation is the wait time, computed as:

Wait time = completion date — decision date

for each AWR record meeting specified inclusion/exclusion criteria, completed on or 365 days prior to the last day of the reporting period.

The 90th percentile wait time targets of 6 weeks for Urgency Level II and 26 weeks for Urgency Level III, as published in the Ministry 2009-2012 Business Plan, are not comparable to the results reported by these urgency levels in 2009/2010. This due to inconsistencies in coding practices in classifying patients waiting for coronary artery bypass graft surgery as Urgency Level II or Urgency Level III. This surgery is performed only at two sites in Alberta (Calgary and Edmonton), and staff at these sites coded urgency levels for CABG using different methods.

Performance Measure 6.a (2) Wait time for: Hip replacement surgery

The result for this measure is based on the time (in weeks) within which 90 per cent of person cases were completed (had their procedure performed as planned). The calculation uses Alberta Waitlist Registry (AWR) records of persons served from April 1 to March 31 of the reporting fiscal year. It does not include persons who voluntarily delayed their procedure, or those who had a scheduled follow-up procedure, or those that received emergency surgical care.

The general definition of a percentile is a point on a rank-ordered scale, found by sorting a group of observations* in order of magnitude from lowest to highest. The first percentile approximates the very lowest/bottom number found, while the 100th percentile is the very highest reported. The nth percentile is the point exceeding n per cent of the observations. For example, a wait time equal to or greater than 90 per cent of other observations is the 90th percentile wait time.

*Each observation is the wait time, computed as:
Wait time = completion date — decision date

for each AWR record meeting specified inclusion/exclusion criteria, completed on or 365 days prior to the last day of the reporting period.

Results are restated for all prior years due to changes in methodology. Calculation of results is now based on data for the entire fiscal year, not data 90 days prior to the last day of March.

Performance Measure 6.a (3) Wait time for: Knee replacement surgery

The result for this measure is based on the time (in weeks) within which 90 per cent of person cases were completed (had their procedure performed as planned). The calculation uses Alberta Waitlist Registry (AWR) records of persons served from April 1 to March 31 of the reporting fiscal year. It does not include persons who voluntarily delayed their procedure, or those who had a scheduled follow-up procedure, or those that received emergency surgical care.

The general definition of a percentile is a point on a rank-ordered scale, found by sorting a group of observations* in order of magnitude from lowest to highest. The first percentile approximates the very lowest/bottom number found, while the 100th percentile is the very highest reported. The nth percentile is the point exceeding n per cent of the observations. For example, a wait time equal to or greater than 90 per cent of other observations is the 90th percentile wait time.

*Each observation is the wait time, computed as:

Wait time = completion date — decision date

for each AWR record meeting specified inclusion/exclusion criteria, completed on or 365 days prior to the last day of the reporting period.

Results are restated for all prior years due to changes in methodology. Calculation of results is now based on data for the entire fiscal year, not data 90 days prior to the last day of March.

Performance Measure 6.a (4) Wait time for: Children's mental health

This measure identifies the wait time to access children's mental health services, based on the 90th percentile wait time (in weeks) from when a child is referred (by family/self or clinician) to the time they receive their first contact with a mental health service provider (enrolment or single session).

The wait time to access children's mental health services is calculated by determining the days between the "Referral Date" and the "Date of First Contact" (subtracting the "Referral Date" from the "Date of First Contact"). The "Date of First Contact" refers to enrolment dates in most cases, but for those children who only have a single-session of treatment who do not get enrolled in a service, a visit disposition field is used to capture the "Date of First Contact".

As in prior years, in 2009/2010 the data are limited to children who were seen in community mental health clinics and limited additional program areas across the province. Wait times for children who accessed inpatient, outpatient, or emergency department services are not included in the calculation of results for this measure. Therefore, results reflect wait times for accessing only a portion of the continuum of mental health services.

Performance Measure 6.b Public rating of access to emergency department services: percentage rating ease of actually obtaining emergency department services needed for self as "easy"

The result for this measure is based on the results of the Health Quality Council of Alberta survey: *Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010.* This measure is defined as the total percentage of respondents who responded "easy" or "very easy" to the question:

"How difficult or easy was it to actually obtain the emergency department services you or your close family member needed most recently"

In 2010, data were collected through a telephone survey of 4,341 randomly selected Alberta households. A total of 1,879 respondents answered the question on the ease of access to obtain emergency department services. Results are reliable within ±2.9 per cent, 19 times out of 20.

Performance Measure 6.c The number of persons waiting in an acute care hospital bed for continuing care placement

The result for this measure is based on submissions from representatives from each of the five geographic Alberta Health Services (AHS) Zones. These AHS Zones are responsible for submitting the number of persons waiting in an acute care hospital bed for continuing care placement to AHS Health System Compliance and Accountability on a monthly basis. This information is submitted to Alberta Health and Wellness on a quarterly basis. The results are reported for the last quarter.

The measure is calculated as the arithmetic sum of persons waiting for continuing care placement in the five geographic AHS zones in all acute care facilities in Alberta as of March 31st in a given fiscal year.

Performance Measure 7.a Number of care providers accessing Alberta Netcare

This measure counts the number of distinct accesses to the EHR by authorized health care providers within the time frame of the annual reporting period. The Provincial EHR, called Alberta Netcare, is a system of inter-functional applications delivered and operated by multiple public and private organizations.

All data used to generate the performance measure is first automatically collected within the databases of the various EHR applications -specifically the Pharmaceutical Information Network (PIN), Lab Test Results History (LTRH), Person's Directory (PD) and Alberta Netcare Portal 2004. Anytime a user accesses, reads, or updates an auditable data record in the EHR applications, an audit record of that access is recorded in that application's database. To generate the EHR performance measure reports, the audit records from the EHR applications that were generated in the appropriate time period are copied from the various applications' databases into a singe reporting database. This dedicated database is maintained and managed through CGI. The CGI's Application Maintenance Services (AMS) team has access and executes the data extraction/copy script. A series of four automated data analysis scripts are run in the appropriate sequence, which perform the appropriate calculations and summaries on the collected raw audit data and writes the results to separate results tables. The final reports are generated directly from the data in the results tables without any alterations or transformations.

All scripts used to generate the reports are triggered by a designated person on the AMS team. The scripts contain all the connection information for all the databases involved. The AMS personnel run the scripts in the correct sequence without needing to manually connect to the databases. The report generation scripts are all stored in the Concurrent Version System (CVS) source code repository. As changes are made to the reporting CVS tracks all versions of the scripts including the user who made the change and the date and time that the change was committed. Only AMS personnel with a valid user id and password are allowed to make changes to the scripts stored in the CVS repository. Some AMS developers are granted read-only access to production databases in order to execute service requests from AHW. Only the AMS database administrators are granted write access to production databases.

Audit records are not accessible (even for viewing) by the end users of the EHR applications. The report generation scripts are always run on an internal server that is only accessible by designated AMS and MO personnel. The report generation scripts do not alter the original audit data in any way. The numbers generated by the scripts are aggregates derived from

the audit records of the EHR applications. The aggregation process is completely automated to ensure the integrity of the data.

Performance Measure 7.b Percentage of Albertans who are aware of Health Link Alberta; Percentage of Albertans who have used Health Link Alberta within the past year

The result for this measure is based on the results of the Health Quality Council of Alberta survey: *Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010*. This measure is defined as the percentage of respondents who responded "yes" to the question:

"Alberta has a province-wide service called "Health Link" which provides Albertans with toll-free access to nurse advice and general health and services information, 24-hours a day, 7 days a week. Were you aware of the Health Link service before today?"

The percentage of respondents who were aware of Health Link Alberta and responded "yes" to the question:

"Have you called Health Link within the past year?"

In 2010, data were collected through a telephone survey of 4,341 randomly selected Alberta households. A total of 4,244 respondents answered the question on awareness of Health Link Alberta. Results are reliable within ±1.7 per cent, 19 times out of 20. A total of 3,187 respondents answered the question on use of Health Link Alberta in the past year. Results are reliable within ±2.1 per cent, 19 times out of 20.

Performance Measure 7.c Percentage of community physicians enrolled in the Physician Office System Program (POSP) and using the electronic medical record in their clinic

The result for this measure is based on information from the Alberta Medical Association (AMA) membership database (MSIS), POSP funding and enrolment database (iPOSP) and Alberta Health Services (AHS) Lab destinations per physician database.

For determination of results for the measure, the numerator is the number of POSP grant-funded physicians using an EMR plus the total number of physicians who have implemented an EMR from a qualified vendor (achieved Milestone 3/Go-Live).

The denominator for this measure is determined using:

1. An extract from the AMA database provides all members and staff positions. Staff, non-physicians and deceased members are removed based on AMA charge codes.
2. Physicians who do not have a work or home address in Alberta are removed. The address is contained in the data from the AMA database.
3. Non-community based physicians are removed based on:
   - Speciality: The specialties are identified as physicians who do not provide primary care to patients in a clinical setting as their point of care is in a hospital or research facility.
   - Lab results: Physicians whose lab results are sent only to an AHS facility or military facility.
4. Physicians who have previously engaged with POSP and are known to be working in an academic facility are removed.

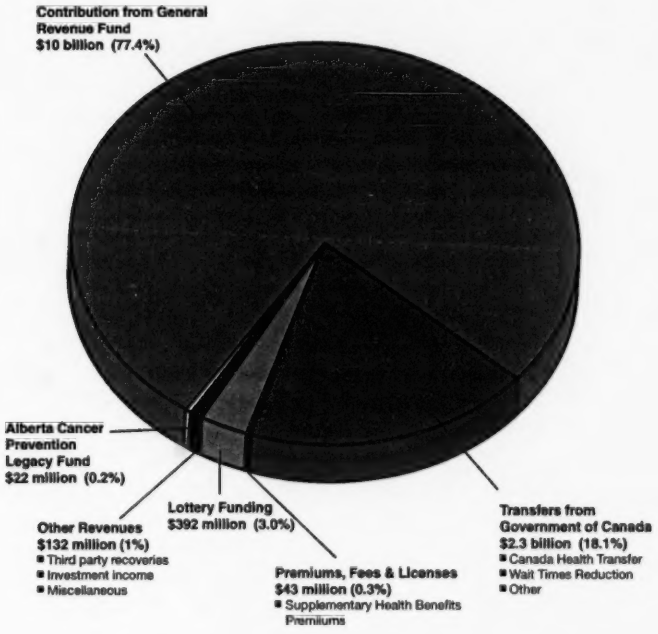
Financial Information

MINISTRY FINANCIAL HIGHLIGHTS

REVENUES

Revenue decreased by $410 million from fiscal 2008/2009 to $2.9 billion. The decrease was primarily due to the elimination of Alberta Health Care Insurance Premiums and lower investment income. Partially offsetting this was an increase in the transfers from the Government of Canada.

Alberta Health and Wellness
Funding Sources
2009/2010



Total – $12.9 Billion

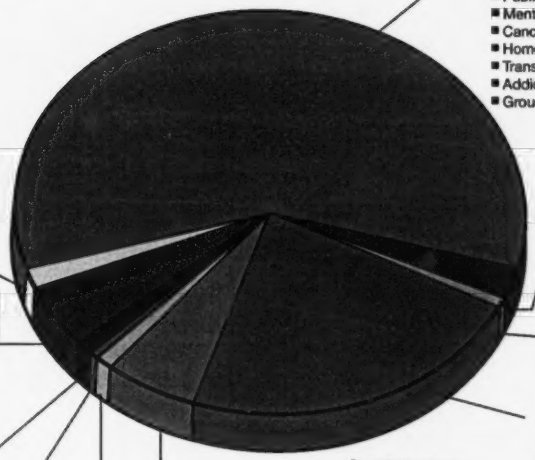
EXPENSES

Several health system cost drivers contributed to increased spending of 0.6 per cent in 2009/2010 (compared to 2008/2009), including Alberta's growing and aging population, health sector wage inflation, drug costs, new technologies and rising expectations for health services.

The majority of funding was provided to Alberta Health Services for operational support of the health system. Excluding one-time funding, Alberta Health Services received a $560 million, or 7.8 per cent increase in base operating funding. One-time funding of $343 million in 2009/2010 was provided to Alberta Health Services to address the accumulated deficit of the former health authorities.

Alberta's physicians received a significant increase from 2008/2009. Additional Physician Services costs of $290 million, or 11.2 per cent, primarily reflect volume increases as well as a negotiated 5 per cent rate increase under the Tri-lateral Master Agreement. Other increases supported the continued operation and expansion of Primary Care Networks and Alternate Relationship Plans.

Alberta Health and Wellness
How Funding was Spent
2009/2010



Alberta Health Services
$7.7 billion (59.6%)
Funding for services such as:
- Acute, Long term care and Continuing care
- Public and community health
- Mental health services
- Cancer treatment
- Home care
- Transplants, cardiac surgery and renal dialysis
- Addiction prevention and treatment
- Ground emergency ambulance, etc.

Infrastructure Support
$211 million (1.6%)
(includes Capital Maintenance funding)

One-time Funding for Alberta Health Services
$343 million (2.6%)
- Funding to address the 2008/2009 deficit of the former health authorities

Other Programs
$633 million (4.9%)
Funding for services such as:
- Out of province health care
- Systems development
- Allied Health Services
- Cancer research and prevention
- Specialized High Cost Drugs
- Medical Resident Allowances
- Safe Communities, etc.

One-time Funding for H1N1 Pandemic Response
$80 million (0.6%)
- Alberta Health Services
- Physician Compensation
- Vaccines

Physician Services
$2.9 billion (22.4%)
- Physician compensation
- On Call programs
- Physician Office System Project
- Primary care
- Academic Alternate Relationship Plans
- Rural Physician Action Plan

Ministry Support Services
$146 million (1.1%)
- Salaries and benefits for Department staff
- Contracted services

Healthy Living & Wellness and Blood Services
$62 million (0.4%)
- Immunization Support
- Community agency grants

Human Tissue and Blood Services
$156 million (1.2%)
- Blood and blood products for the health system

Supplementary Health Benefits
$722 million (5.6%)
- Ministry sponsored program including pharmaceuticals and other benefits such as ground ambulance, prosthetics and orthotics

Base Funding – $12.5 Billion
One-Time Funding – $423 Million
Total – $12.9 Billion

The costs for Alberta's response to the H1N1 pandemic were $80 million and include vaccines, physician office visits and funding to Alberta Health Services. A supplementary estimate was approved for this unanticipated expense. The actual costs were significantly lower than the original estimate since wave three did not materialize as originally expected.

Support for health capital infrastructure projects was reduced to reflect requirements and savings were realized from the elimination of the partial subsidy for chiropractic services.

CAPITAL PLAN

In 2009/2010, the health capital plan funded the completion of two new ambulatory care projects: the Eastwood Primary Health Care Centre in Edmonton and a primary care clinic in the Sheldon M. Chumir Health Centre in Calgary. Other completed ambulatory care projects included the emergency department renovation and expansion at the Northern Lights Regional Health Centre in Fort McMurray and the Richmond Road Diagnostic and Treatment Centre in Calgary. In addition, work started or continued on the renovation and expansion of the emergency department and the endoscopy suite in Grande Prairie's Queen Elizabeth II Hospital, the Edmonton Clinic and the East Calgary Health Centre. Planning and design was in progress for the Strathcona Hospital (Phase 1) in Sherwood Park.

Acute care projects completed included the expansion of the Peter Lougheed Centre in Calgary, the new Robbins Pavilion (including the Lois Hole Hospital for Women) at the Royal Alexandra Hospital and the redevelopment of the Grey Nuns Community Hospital in Edmonton. Acute care projects in progress included the expansion of the Foothills Medical Centre, the Rockyview General Hospital in Calgary and the expansion of the Sturgeon Community Hospital in St. Albert. Other projects included the construction of the new South Calgary Health Campus, a new orthopedic surgical facility at the Royal Alexandra Hospital and the replacement of the Fort Saskatchewan Health Centre.

A new radiation therapy facility was built, which will expand the cancer services delivered at the Chinook Regional Hospital in Lethbridge. Also the planning and design continued for the new cancer radiation therapy facility at the Red Deer Regional Hospital.

The Garrison Green Care Centre, a new long-term care facility in Calgary, was completed. Other continuing care projects in progress included the replacement of the Good Samaritan Care Centre in Stony Plain, the new Extendicare Eau Claire facility in Edmonton and the new Michener Hill Village in Red Deer. The planning and design phase was started for the replacement of the Dr. Cooke Extended Care Centre in Lloydminster.

Other projects completed or underway include upgrading the sterile supply rooms in seven rural hospitals, constructing the Child and Adolescent Services Association (CASA) House in Sherwood Park, and developing the new Villa Caritas mental health facility in Edmonton.

Financial Information

Ministry of Health and Wellness

Consolidated Financial Statements

March 31, 2010

MINISTRY OF HEALTH AND WELLNESS

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2010

Auditor's Report

Consolidated Statements of Operations

Consolidated Statements of Financial Position

Consolidated Statements of Cash Flows

Notes to the Consolidated Financial Statements

Schedule 1 - Consolidated Revenues

Schedule 2 - Consolidated Expenses-Directly Incurred Detailed by Object

Schedule 3 - Reconciliation of Budget with Actual

Schedule 4 - Consolidated Related Party Transactions

Schedule 5 - Consolidated Allocated Costs

Schedule 6 - Consolidated Portfolio Investments

AUDITOR GENERAL
Alberta

Auditor's Report

To the Members of the Legislative Assembly

I have audited the consolidated statements of financial position of the Ministry of Health and Wellness as at March 31, 2010 and 2009 and the consolidated statements of operations and cash flows for the years then ended. These financial statements are the responsibility of the Ministry's management. My responsibility is to express an opinion on these financial statements based on my audits.

I conducted my audits in accordance with Canadian generally accepted auditing standards. Those standards require that I plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In my opinion, these consolidated financial statements present fairly, in all material respects, the financial position of the Ministry as at March 31, 2010 and 2009 and the results of its operations and its cash flows for the years then ended in accordance with Canadian generally accepted accounting principles.

[Original signed by Merwan N. Saher]

CA
Auditor General

Edmonton, Alberta
June 11, 2010

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED STATEMENTS OF OPERATIONS
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2010	2009 (Restated - Note 3)
Revenues (Schedule 1)		
Internal Government Transfers	$ 457,341	$ 322,531
Transfers from the Government of Canada	2,329,159	2,050,857
Premiums and Fees	640,759	1,375,711
Investment Income	47,771	70,304
Other Revenue	599,117	580,256
	4,074,147	4,399,659
Expenses - Directly Incurred (Note 2b(iv) and Schedules 2 & 5)		
Programs		
Physician Services	2,573,693	2,315,941
Supplementary Health Benefits	721,683	670,381
Healthy Living and Wellness	381,584	354,685
Provincial Programs	171,914	176,721
Facility Based Patient Care	4,423,799	4,244,506
Community Based & Home Care	1,058,635	907,853
Diagnostic,Therapeutic & Other Patient Services	2,347,539	1,978,214
Research and Education	237,233	241,511
Health Service Delivery Support	1,431,930	1,482,866
Administration & Support Services	908,458	830,425
Other	148,765	154,690
	14,405,233	13,357,793
Valuation Adjustments		
Health Care Insurance Premium Revenue (Recoveries) / Write-Offs	(14,851)	82,258
Other Write-Offs	24,526	13,645
Provision for Vacation Pay	17,974	27,280
	27,649	123,183
(Loss) on disposal of Tangible Capital Assets and Write-down of Inventory	(14,880)	(35,373)
Net Operating results	$ (10,373,615)	$ (9,116,690)

The accompanying notes and schedules are part of these consolidated financial statements.

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED STATEMENTS OF FINANCIAL POSITION
AS AT MARCH 31
(in thousands)

	2010	2009 (Restated - Note 3)
ASSETS		
Cash and Temporary Investments (Note 5)	$ 1,701,626	$ 2,557,047
Portfolio Investments (Schedule 6)	544,945	613,180
Accounts Receivable (Note 6)	271,067	279,534
Tangible Capital Assets (Note 7)	6,270,111	5,631,173
Inventory	127,115	118,236
Prepaid Expenses	56,488	47,354
	$ 8,971,352	$ 9,246,524
LIABILITIES		
Accounts Payable and Accrued Liabilities (Note 8)	$ 1,757,929	$ 2,073,068
Deferred Revenue (Note 9)	325,745	391,737
Notes, Debentures and Mortgages (Note 10)	275,704	201,285
	2,359,378	2,666,090
NET ASSETS		
Net Assets at Beginning of Year	6,580,434	5,501,156
Net Operating Results	(10,373,615)	(9,116,690)
Net Financing provided from General Revenues	10,405,155	10,195,968
Net Assets at End of Year (Note 13)	6,611,974	6,580,434
	$ 8,971,352	$ 9,246,524

The accompanying notes and schedules are part of these consolidated financial statements.

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2010	2009 (Restated - Note 3)
Operating Transactions		
Net Operating Results	$ (10,373,615)	$ (9,116,690)
Non-cash items:		
Health Care Insurance Premium Revenue Write-Offs	-	82,258
Other Write-Offs	24,526	13,645
Provision for Vacation Pay	17,974	27,280
Amortization of Tangible Capital Assets (Schedule 2)	433,192	395,953
Loss on Disposal of Tangible Capital Assets and and Write-down on inventory	14,880	35,373
(Gain)/Loss on disposal of Portfolio Investments	(6,526)	7,437
	(9,889,569)	(8,554,744)
(Increase) / Decrease in Accounts Receivable	(16,060)	119,725
(Increase) / Decrease in Prepaid Expenses	(9,134)	86,796
(Increase) in Inventory	(20,200)	(13,907)
(Decrease) in Accounts Payable and Accrued Liabilities	(333,113)	(106,744)
(Decrease) in Deferred Revenue	(65,992)	(117,704)
Cash (applied to) Operating Transactions	(10,334,068)	(8,586,578)
Capital Transactions		
Acquisition of Tangible Capital Assets	(1,075,689)	(1,197,819)
Proceeds on disposal of Tangible Capital Assets	-	441
Cash (applied to) Capital Transactions	(1,075,689)	(1,197,378)
Investing Transactions		
Purchase of Portfolio Investments	(398,048)	(651,974)
Proceeds on sale of Portfolio Investments	472,809	710,880
Cash provided by Investing Transactions	74,761	58,906
Financing Transactions		
Net Financing provided from General Revenues	10,405,155	10,195,968
Principal payments of Notes, Debentures and Mortgages	(14,410)	(10,119)
Proceeds from Notes, Debentures and Mortgages	88,830	55,417
Cash provided by Financing Transactions	10,479,575	10,241,266
(Decrease)/Increase in Cash	(855,421)	516,216
Cash, Beginning of Year	2,557,047	2,040,831
Cash, End of Year	$ 1,701,626	$ 2,557,047

The accompanying notes and schedules are part of these consolidated financial statements.

MINISTRY OF HEALTH AND WELLNESS
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31

Note 1 Authority and Purpose

The Minister of Health and Wellness (Minister) has been designated responsibilities for various Acts by the *Government Organization Act*. To fulfill these responsibilities, the Minister administers the organizations listed below. The authority under which each organization operates is also listed. Together these organizations form the Ministry of Health and Wellness (Ministry).

Department of Health and Wellness	*Government Organization Act*
Alberta Health Services	*Regional Health Authorities Act*
Health Quality Council of Alberta	*Regional Health Authorities Act*
Calgary Health Trust	*Regional Health Authorities Act*
Alberta Cancer Foundation	*Regional Health Authorities Act*

Effective April 1, 2009, the name of East Central Health was amended to Alberta Health Services. All other Regional Health Authorities, the Alberta Mental Health Board, the Alberta Cancer Board and the Alberta Alcohol and Drug Abuse Commission were disestablished and incorporated with Alberta Health Services.

The purpose of the Ministry is to maintain and improve the health of Albertans by providing increased access to quality health care and improve the efficiency and effectiveness of health care service delivery. The Ministry is also engaged in inter-ministerial initiatives to effectively address challenges to the health and well-being of the population.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

These financial statements are prepared in accordance with Canadian generally accepted accounting principles for the public sector as recommended by the Public Sector Accounting Board (PSAB) of the Canadian Institute of Chartered Accountants. The PSAB financial statements presentation for government summary financial statements has been modified to more appropriately reflect the nature of the Ministry, which includes the financial statements of the Department and its controlled entities on a line by line consolidation basis.

(a) Reporting Entity and method of consolidation

The reporting entity is the Ministry of Health and Wellness, for which the Minister of Health and Wellness is accountable. These financial statements include the accounts of the following entities:

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(a) Reporting Entity and method of consolidation (continued)

Department of Health and Wellness
Alberta Health Services (AHS)
Health Quality Council of Alberta (HQCA)
Calgary Health Trust
Alberta Cancer Foundation

The accounts of the above entities are consolidated on line-by-line basis after adjusting them to a basis consistent with the accounting policies described below. Revenue and expense transactions, capital, investing, and financing transactions, and related asset and liability balances between consolidated entities have been eliminated.

The Ministry has entered into various partnerships with one or more partners outside the reporting entity to establish Primary Care Networks. The Ministry has also entered into a partnership with the University of Alberta to establish the Northern Alberta Clinical Trials Centre. The Ministry and its partners share, on an equitable basis, the significant risks and benefits associated with operating the partnership. The Ministry's 50 per cent interests in these partnerships are included in these financial statements under the proportionate consolidation method. The Ministry includes its proportionate share of assets, liabilities, revenues and expenses on a line-by-line basis, after conforming the accounting policies and eliminating its proportionate share of the balances and transactions with the partnerships.

(b) Basis of Financial Reporting

(i) Revenues

All revenues are reported on the accrual basis of accounting. Cash received for which goods or services have not been provided or used for purposes specified by year end are recorded as unearned revenue or included in accounts payable and accrued liabilities.

(ii) Internal Government Transfers

Internal government transfers are transfers between entities within the government reporting entity where the entity making the transfer does not receive any goods or services directly in return. Restricted internal government transfers are reported as liabilities and included in deferred revenue until the transfer is used for the purposes specified. Unrestricted internal government transfers are recognized in revenue when received.

(iii) Transfers from the Government of Canada

Transfers from Government of Canada are recognized as revenues when authorized by federal legislation or federal/provincial agreements, eligibility criteria if any are met and a reasonable estimate of the amounts can be made. Overpayments relating to Canada Health Transfers and other transfers received before revenue recognition criteria have been met are included in either Unearned Revenue or Accounts Payable and Accrued Liabilities.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Basis of Financial Reporting (continued)

(iv) Expenses

Directly Incurred

Directly incurred expenses are those costs for which the Ministry has primary responsibility and accountability for.

In addition to program operating expenses such as grants, salaries, supplies etc., directly incurred expenses also include:

- amortization of tangible capital assets.
- inventory consumed.
- pension costs, which are the cost of employer contributions during the year.
- valuation adjustments which include changes in the valuation allowances used to reflect financial assets at their net recoverable or other appropriate value. Valuation adjustments also represent the change in management's estimate of future payments arising from obligations relating to vacation pay.

Grants are recognized as expenses when authorized, eligibility criteria, if any, are met, and a reasonable estimate of the amounts can be made.

Incurred by Others

Services contributed by other entities in support of the Ministry's operations are not recognized and are disclosed in Schedule 4 and 5.

(v) Assets

Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations. Financial assets of the Ministry are limited to cash and financial claims, such as advances to and receivables from other organizations, employees and other individuals.

Assets acquired by right are not included. Tangible capital assets of the Ministry are recorded at historical cost which includes all amounts directly attributable to the acquisition, construction, development or betterment of the asset. Tangible capital assets are amortized on a straight-line basis over the estimated useful lives of the assets. The threshold for capitalizing new systems development is $250,000 and the threshold for major enhancements is $100,000. The threshold for all other tangible capital assets is $5,000. All land is capitalized.

Inventory is valued at the lower of cost and net realizable value and is determined on a first-in, first-out basis.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Basis of Financial Reporting (continued)

(vi) Liabilities

Liabilities are recorded to the extent that they represent present obligations as a result of events and transactions occurring prior to the end of the fiscal year. The settlement of liabilities will result in sacrifice of economic benefits in the future.

(vii) Net Assets

Net assets represent the difference between the carrying value of assets held by the Ministry and its liabilities.

(viii) Valuation of Financial Assets and Liabilities

Fair value is the amount of consideration agreed upon in an arm's length transaction between knowledgeable, willing parties who are under no compulsion to act.

The fair values of cash and temporary investments, accounts receivable, advances, accounts payable and accrued liabilities are estimated to approximate their carrying values because of the short-term nature of these instruments.

Public fixed-income securities and equities are valued at the average of the latest bid and ask prices.

The fair value of long term debt is an approximation of its fair value to the holder.

(ix) Contracted Health Service Operators

To account for the full extent of the Ministry's responsibility for the provision of health services in Alberta, fees and charges earned by the contracted health service operators for designated services are recorded as revenue. An equivalent amount is recorded as contracted health services expense. Also, grants paid to contracted health services operators are reclassified as program expense.

(x) Measurement Uncertainty

Measurement uncertainty exists when there is a significant variance between the recognized or disclosed amount and another reasonably possible amount. Measurement uncertainty that is material to these financial statements exists in the accrual of Canada Health Transfer. The nature of uncertainty for Canada Health Transfers can arise from changes in the base allocations which are primarily a result of updated personal and corporate tax information or from new entitlement with little historical experience.

Note 3 Reporting Changes
(in thousands)

As explained in note 2, the Ministry consolidates all controlled entities on a line-by-line basis. Previously, AHS and HQCA were included in the Ministry's consolidated financial statements on a modified equity basis. Also Calgary Health Trust and Alberta Cancer Foundation were previously excluded from the Ministry reporting entity. This change in accounting policy has been retrospectively applied.

As a result of transfer of responsibility for programs between the Ministry of Health and Wellness and the Ministry of Infrastructure and Ministry of Seniors and Community Support, the comparatives for 2008/2009 have been restated as if the respective Ministries had always been assigned with its current responsibilities.

The following is a summary of the effect of the reporting changes on the 2008/2009 financial statements:

	March 31, 2009		
	As Previously Reported	Increase/ (Decrease)	As Restated
[1] Revenues	$ 3,171,530	$ 1,228,129	$ 4,399,659
[2] Expenses	12,881,070	635,279	13,516,349
[3] Net Operating Results	(9,709,540)	592,850	(9,116,690)
[4] Net Financing provided from General Revenues	10,201,168	(5,200)	10,195,968
Net Assets(Liabilities) at March 31, 2008	(800,734)	6,301,890	5,501,156
[4] Net Change in Fair Values	(44,019)	44,019	-
Net Assets(Liabilities) at March 31, 2009	$ (353,125)	$ 6,933,559	$ 6,580,434

[1] Revenues increased because of the change in the method of reporting the results of AHS and HQCA.

[2] Expenses increased because of the change in the method of reporting the results of AHS and HQCA $640,479 and transfer of responsibilities between the Departments of Health and Wellness and the Department of Infrastructure $248 and Department of Seniors and Community Support ($5,448).

[3] Net financing provided from General Revenue decreased because of the transfer of responsibilities between the Departments of Health and Wellness and the Department of Infrastructure and Department of Seniors and Community Support.

[4] Net assets increased and net change in fair values increased because of the change in method of reporting the results of AHS and HQCA.

Note 4 H1N1 Pandemic Response
(in thousands)

During the year the Ministry responded to the need for providing health awareness, vaccination and assessment clinics, and emergency and acute care for the outbreak of H1N1 influenza. The following costs in the mentioned programs are included in the Statements of Operations.

	2010	2009
Physician compensation	$ 15,696	$ -
Vaccines dispensed	5,760	-
Facility Based Patient Care	19,674	-
Diagnostic, Therapeutic & Other services	5,646	-
Healthy Living and Wellness	22,619	-
Other	1,014	-
	70,409	-
Write-down of expired vaccines	4,678	-
	$ 75,087	$ -

Note 5 Cash and Temporary Investments
(in thousands)

Cash and temporary investments include deposits in the Consolidated Cash Investment Trust Fund (CCITF) of the Province of Alberta. The CCITF is managed with the objective of providing competitive interest income to depositors while maintaining appropriate security and liquidity of depositors' capital. The portfolio is comprised of high quality, short-term and mid-term fixed income securities with a maximum term to maturity of three years. For the year ended March 31, 2010, securities held by the Fund had a time-weighted return of 1.0% per annum (March 31, 2009: 3.0% per annum).

	2010	2009 (Restated -Note 3)
Cash	$ 1,701,124	$ 2,377,905
Term Deposits	-	1,827
Money Market Securities	-	68,373
Treasury Bills	502	108,942
Total	$ 1,701,626	$ 2,557,047

Note 6 Accounts Receivable
(in thousands)

	2010			2009
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	(Restated - Note 3) Net Realizable Value
Accounts receivable	$ 297,062	$ (36,090)	$ 260,972	$ 263,402
Other receivable	10,095	-	10,095	16,132
Total	$ 307,157	$ (36,090)	$ 271,067	$ 279,534

Note 7 Tangible Capital Assets
(in thousands)

	2010								2009
	Land	Buildings [1] 10-40 years	Land Improvements 5-25 years	Equipment 2-20 years	Computer Hardware and Software 3-10 years	Leasehold Assets Term of Lease	Others [2]	Total	Total (Restated - Note 3)
Historical Cost									
Beginning of year	$ 106,330	$ 5,000,137	$ 63,045	$ 1,461,073	$ 803,936	$ 148,748	$ 1,515,163	$ 9,098,432	$ 8,042,333
Additions	-	436,624	478	142,109	150,572	8,020	337,886	1,075,689	1,197,819
Disposals, including write-downs	-	(7,328)	(45)	(38,506)	(22,002)	-	-	(67,881)	(141,720)
	106,330	5,429,433	63,478	1,564,676	932,506	156,768	1,853,049	10,106,240	9,098,432
Accumulated Amortization									
Beginning of year	-	1,991,147	41,303	896,017	485,971	52,821	-	3,467,259	3,177,212
Amortization expense	-	138,827	4,469	162,399	114,222	13,275	-	433,192	395,953
Effect of disposals	-	(4,646)	(45)	(37,629)	(22,002)	-	-	(64,322)	(105,906)
	-	2,125,328	45,727	1,020,787	578,191	66,096	-	3,836,129	3,467,259
Net Book Value at March 31, 2010	$ 106,330	$ 3,304,105	$ 17,751	$ 543,889	$ 354,315	$ 90,672	$ 1,853,049	$ 6,270,111	
Net Book Value at March 31, 2009	$ 106,330	$ 3,008,990	$ 21,742	$ 565,056	$ 317,965	$ 95,927	$ 1,515,163		$ 5,631,173

[1] Buildings include parking lots

[2] Others include work in progress

Note 8 Accounts Payable and Accrued Liabilities
(in thousands)

	2010	2009 (Restated-Note 3)
Accounts Payable & Accrued Liabilities	$ 1,392,660	$ 1,725,773
Accrued vacation pay	365,269	347,295
	$ 1,757,929	$ 2,073,068

The Ministry recognizes the fair value of the asset retirement obligations associated with tangible capital assets as liabilities and adjustments to the carrying values of the relevant tangible capital assets. These adjustments are amortized over the remaining useful life of the assets. The asset retirement obligation is recognized when it is possible to estimate the fair value of the obligation.

Accounts payable and accrued liabilities above include asset retirement obligations of $11,474 (2009 - $13,767). Asset retirement obligations represent the legal obligation to remove asbestos during planned renovations at certain of the Ministry's health services facilities.

Note 9 Deferred Revenue
(in thousands)

	2010	2009 (Restated-Note 3)
Deferred Contributions	$ 246,720	$ 244,549
Deferred Capital Contributions	52,126	85,459
Unearned Revenue	26,899	61,729
	$ 325,745	$ 391,737

Note 10 Notes, Debentures and Mortgages
(in thousands)

	Maturity	Interest Rate	2010 Carrying Value	2010 Fair Value	2009 (Restated - Note 3) Carrying Value	2009 (Restated - Note 3) Fair Value
Debentures[a]	2013 to 2031	4.40-4.93%	$ 176,662	$ 180,340	$ 182,982	$ 188,393
Mortgages			-	-	2,022	2,022
Bank Loan	September 2011	2.76%	83,000	83,000	326	326
			259,662	263,340	185,330	190,741
Capital Lease Obligation	2011 to 2028	6.50%	16,042	18,902	15,955	19,203
Total			$ 275,704	$ 282,242	$ 201,285	$ 209,944

[a] The debentures have been issued by AHS to Alberta Capital Finance Authority (ACFA).

The Ministry is committed to making payments as follows:

	Debentures Payable and Bank Loan	Capital Leases	Total
2010-11	$ 11,852	$ 1,716	$ 13,568
2011-12	98,113	1,659	99,772
2012-13	15,277	1,465	16,742
2013-14	10,040	1,453	11,493
2014-15	6,870	1,453	8,323
Thereafter	117,510	19,752	137,262
Less: amount representing interest under leases	-	(11,456)	(11,456)
	$ 259,662	$ 16,042	$ 275,704

Note 11 Contractual Obligations
(in thousands)

Contractual Obligations are obligations of the Ministry to others that will become liabilities in future when the terms of those contracts or agreements are met. As at March 31, 2010, the Ministry has the following contractual obligations:

	2010	2009 (Restated - Note 3)
Specific programs commitments	$ 522,897	$ 975,836
Capital construction contracts	1,562,025	2,249,018
Service contracts and operating leases	302,004	267,866
	$ 2,386,926	$ 3,492,720

Note 11 Contractual Obligations (continued)
(in thousands)

The aggregate amounts payable for the unexpired terms of these contractual obligations are as follows:

	Specific Programs Commitments	Capital Construction Contracts	Service Contracts and operating leases	Total
2011	$ 489,151	$ 841,973	$ 100,451	$ 1,431,575
2012	16,470	488,253	47,710	552,433
2013	4,525	179,420	41,902	225,847
2014	4,256	52,311	26,597	83,164
2015	4,224	5	21,455	25,684
Thereafter	4,271	63	63,889	68,223
	$ 522,897	$ 1,562,025	$ 302,004	$ 2,386,926

Canadian Blood Services

The Government of Alberta is committed to provide funding to the Canadian Blood Services (CBS) for the provision of blood services in Canada. This commitment was outlined in a Memorandum of Understanding, signed in January 1998, which recorded the understandings and commitments of the Minister of Health of Canada and the Provincial and Territorial Ministers of Health (except Quebec) regarding their respective roles and responsibilities in a renewed national blood system.

The Province's obligation for the operational costs of CBS is determined on a per capita basis, and the costs for fractionated blood and blood products is determined on the basis of annual utilization of these products. During the year, payments to CBS amounted to $156,274 (2009 - $140,175). Budgeted expenditure for the 2011 fiscal year is $162,702.

Note 12 Contingencies, Equity Agreements with Voluntary Hospital Owners and Indemnity
(in dollars)

Hepatitis C

In June 1999, the Federal, provincial and territorial governments entered into an agreement to provide financial assistance to Canadians who were affected by the Hepatitis C virus through the Canadian blood system during the period from January 1, 1986 to July 1, 1990. The agreement provided for a total federal, provincial and territorial contribution of $1.1 billion plus interest. Interest is calculated and accrued quarterly on the outstanding balance at a rate equal to the 3 month Government of Canada Treasury Bill rate for the quarter. In the fiscal year 1999/2000, the Ministry accrued $30 million; representing Alberta's estimated proportionate share of the financial assistance, excluding accrued interest. At March 31, 2010, the outstanding unpaid balance, including Alberta's proportionate share of the accrued interest, was $17.7 million (2009-$17.9 million).

Note 12 Contingencies, Equity Agreements with Voluntary Hospital Owners and Indemnity (continued)
(in dollars)

Equity Agreements with Voluntary Hospital Owners

The Ministry has a contingent liability for buy-out of equity under Equity Agreements entered into between the Ministry and Voluntary Hospital Owners. The Ministry's payout liability is contingent upon notification by the voluntary hospital owner of termination of the equity agreement. At March 31, 2010, the contingent payout liability upon termination is estimated at $12.8 million (2009 - $12.8 million).

Other Contingencies

At March 31, 2010, the Ministry was named as defendant in 378 legal actions; the outcome of which is indeterminable. 324 of these claims have specified amounts totaling $914.6 million and the remaining 54 have no specified amount. Included in the total legal actions are 20 claims amounting to $315.4 million in which the Ministry has been jointly named with other entities and individuals. 333 claims amounting to $469.3 million are covered by either the Alberta Risk Management Fund or other insurance carriers. 2 claims amounting to $205.9 million are partially covered by Alberta Risk Management Fund. The resulting loss, if any, from these claims cannot be determined.

Indemnity

As described in Note 11, CBS provides blood services in Alberta. CBS has established two wholly-owned captive insurance corporations, CBS Insurance Company Limited (CBSI) and Canadian Blood Services Captive Insurance Company Limited (CBSE). CBSI provides insurance coverage up to $250.0 million with respect to risks associated with the operation of the blood system.

Effective September 28, 2006, CBSE has entered into an agreement whereby the provinces (except Quebec) and territories guarantee and indemnify the risks of operation of the blood system in the amount of $750.0 million in excess of the $250.0 million provided by the insurance coverage from CBSI. Alberta's Pro Rata Share of the $750.0 million is 13.1 per cent or $98.0 million. Authority for Alberta to provide the indemnity under the CSA is pursuant to section 5.05 of the Indemnity Authorization Regulation 22/1997, under the *Financial Administration Act*.

The expense recognition criterion for the indemnity is notification from the CBS that the indemnity is required. At March 31, 2010, no amount has been recognized for this indemnity.

Note 13 Endowment Funds
(in thousands)

Endowment funds are included in net assets and are represented by financial assets amounting to $50,875 (2009 - $49,921). Donors have placed restrictions on their contribution to the endowment funds. The principal restriction is that the original contribution should not be spent.

Note 14 Reciprocal Insurance Arrangement
(in thousands)

AHS participates in a reciprocal insurance arrangement with other health care organizations to share the insurable liability and property risks. The arrangement is established and registered under the *Insurance Act (the Act)* as the Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP).

The plan participants do not have ongoing access to the net assets of the plan which are retained to provide for the potential deterioration of the accrued claims and future catastrophic claims. However, if, in the opinion of the plan administrator, the net assets are in excess of the requirements to meet the plan's obligations, the administrator may apply the excess to reduce future premiums. Under *the Act* the plan is required to maintain two reserves; a reserve fund and a guarantee fund, which as at December 31, 2009 totalled $76,547. If the net assets are insufficient to cover the cost of the claims, participants maybe required to pay additional assessments.

The financial results of LPIP are as follows:

		December 31, 2009		December 31, 2008
Total assets	$	87,468	$	75,959
Total liabilities		73,605		61,534
Net assets	$	13,863	$	14,425
Revenues	$	12,332	$	11,950
Expenses		19,714		15,439
Underwriting loss		(7,382)		(3,489)
Investment income/(loss)		6,820		(1,249)
Net loss	$	(562)	$	(4,738)

Note 15 Trust Funds under Administration
(in thousands)

Trust funds under administration are funds consisting of public money over which the Legislature has no power of appropriation. Because the Ministry has no equity in the funds and administers them for the purposes of various trusts, they are not included in the consolidated financial statements. As at March, 2010, trust fund was under administration were as follows:

	2010	2009 (Restated - Note 3)
Research and development, education and others	$ 6,558	$ 7,081

Note 16 Benefit Plans
(in thousands)

Except as noted below, the Ministry participates in the multi-employer pension plans, Management Employees Pension Plan (MEPP) and Public Service Pension Plan (PSPP). The Ministry also participates in the multi-employer Supplementary Executive Retirement Plan (SERP) for Public Service Managers. The expense for these pension plans is equivalent to the annual contributions.

Alberta Health Services also participates in the Local Authorities Pension Plan (LAPP), which is a multi-employer defined benefit plan. The pension expense for this plan is equivalent to the annual contributions. In addition, Alberta Health Services also participates in defined contribution plan.

Alberta Health Services provides defined supplementary executive retirement plan for certain management staff. The cost of these benefits is actuarially determined on an annual basis using the projected benefit method pro-rated on services, a market interest rate, and management's best estimate of expected costs and the period of benefit coverage.

At March 31, 2010, these plans have net accrued benefit asset of $6,156 (2009 - net accrued benefit liability of $14,529). The accrued benefit asset/liability is included in accounts payable and accrued liabilities.

At December 31, 2009, the Management Employees Pension Plan reported a deficiency of $483,199 (2008 - $568,574) and the Public Service Pension Plan reported a deficiency of $1,729,196 (2008 - $1,187,538). At December 31, 2009, the Supplementary Retirement Plan for Public Service Managers had a deficiency of $39,516 (2008 – $7,111).

At December 31, 2009, the Local Authorities Pension Plan reported an actuarial deficiency of $3,998,614 (2008 - $4,413,971).

Ministry's pension expense for the year is as follows:

	2010	2009 (Restated - Note 3)
Registered Benefit Plans	$ 307,994	$ 260,089
SERP	4,237	6,848
Defined Contribution Plan	11,326	9,808
Expense of transferring PSPP service to LAPP	33,000	7,000
	$ 356,557	$ 283,745

The Ministry also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2010, the Bargaining Unit Plan reported an actuarial deficiency of $8,335 (2009 - $33,540) and the Management, Opted Out and Excluded Plan reported an actuarial surplus of $7,431 (2009 - deficiency of $1,051). The expense for these two plans is limited to the employer's annual contributions for the year.

Note 17 Comparative Figures

Certain 2009 figures have been reclassified, where necessary, to conform to the 2010 presentation.

Note 18 Subsequent Events

Effective April 1, 2010, the responsibility for Health Facilities Infrastructure will be transferred over to the Department of Infrastructure.

Note 19 Approval of Financial Statements

The consolidated financial statements were approved by the Senior Financial Officer and the Deputy Minister.

Schedule 1

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED SCHEDULES OF REVENUES
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2010	2009 (Restated - Note 3)
Internal Government Transfers		
Transfer from the Lottery Fund	$ 392,034	$ 260,495
Transfer from Alberta Cancer Prevention Legacy Fund	21,874	19,257
Transfer from Other Government Departments	43,433	42,779
	457,341	322,531
Transfers from Government of Canada		
Canada Health Transfer	2,260,243	1,947,239
Wait Times Reduction	27,316	61,222
Other Health Transfers	41,600	42,396
	2,329,159	2,050,857
Premiums and Fees		
Health Care Insurance Premiums*	-	758,707
Supplementary Health Benefit Premiums	42,305	25,904
Fees and Charges	598,192	588,840
Other	262	2,260
	640,759	1,375,711
Investment Income	47,771	70,304
Other revenue		
Third Party Recoveries	93,187	90,000
Previous years' refunds of expenditure	20,520	34,037
Donations to Alberta Health Services	129,929	229,783
Other	355,481	226,436
	599,117	580,256
	$ 4,074,147	$ 4,399,659

*Health Care Insurance Premiums have been eliminated effective January 1, 2009

Schedule 2

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED SCHEDULES OF EXPENSES - DIRECTLY INCURRED DETAILED BY OBJECT
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2010	2009 (Restated - Note 3)
Grants	$ 3,688,055	$ 3,434,473
Supplies and Services	4,006,984	3,840,804
Salaries, Wages and Employee Benefits	5,541,946	5,026,920
Amortization of Tangible Capital Assets	433,192	395,953
Inventory Consumed	726,081	652,448
Financial Transactions and Others	8,975	7,195
	14,405,233	13,357,793
Valuation Adjustments		
Health Care Insurance Premium (Recoveries) / Write-Offs	(14,851)	82,258
Other Write-Offs	24,526	13,645
Provision for Vacation Pay	17,974	27,280
Total Expenses	$ 14,432,882	$ 13,480,976

MINISTRY OF HEALTH AND WELLNESS
RECONCILIATION OF BUDGET WITH ACTUAL
FOR THE YEAR ENDED MARCH 31, 2010
(in thousands)

	Budget	Actuals without SUCH sector	Actuals SUCH sector	Adjustments	Actuals with SUCH sector
REVENUES					
Internal Government Transfers					
Transfer from Lottery Fund	$ 392,034	$ 392,034	$ -	$ -	$ 392,034
Transfer from Alberta Cancer Research Prevention Legacy Fund	25,000	21,874	-	-	21,874
Transfer from Alberta Health / Other Departments	-	-	8,968,460	(8,925,027)	43,433
	417,034	413,908	8,968,460	(8,925,027)	457,341
Transfers from Government of Canada					
Canada Health Transfer	1,961,782	2,260,243	-	-	2,260,243
Wait Times Reduction	26,956	27,316	-	-	27,316
Other Health Transfers	47,691	41,600	-	-	41,600
	2,036,429	2,329,159	-	-	2,329,159
Premiums and Fees					
Supplementry Health Benefit Premiums	34,000	42,305	-	-	42,305
Fees and Charges	-	-	598,192	-	598,192
Others	190	262	-	-	262
	34,190	42,567	598,192	-	640,759
Investment Income	32,000	11,944	35,827		47,771
Other Revenue					
Third Party Recoveries	94,300	93,187	-	-	93,187
Previous years' refunds of expenditure	-	20,520	-	-	20,520
Donations	-	-	101,662	28,267	129,929
Other	2,346	6,448	653,508	(304,475)	355,481
	96,646	120,155	755,170	(276,208)	599,117
Total Revenues	2,616,299	2,917,733	10,357,649	(9,201,235)	4,074,147
EXPENSES					
Grants	12,625,680	12,690,916	-	(9,002,861)	3,688,055
Supplies and Services	130,252	100,723	3,975,550	(69,289)	4,006,984
Salaries, Wages and Employee Benefits	76,096	74,364	5,470,874	(3,292)	5,541,946
Amortization of Tangible Capital Assets	29,979	24,569	408,623	-	433,192
Inventory Consumed	45,751	43,674	682,407	-	726,081
Financial Transactions and Others	113	130	8,845	-	8,975
Total Expenses	12,907,871	12,934,376	10,546,299	(9,075,442)	14,405,233
Valuation Adjustments					
Cancer Research and Prevention Investment	25,000	21,874	-	(21,874)	-
Health Care Insurance Premium Revenue (Recoveries) / Write-offs	-	(14,851)	-	-	(14,851)
Other Write-Offs	2,000	3,977	20,549	-	24,526
Provision for Vacation Pay	-	124	17,850	-	17,974
Total Expenses	$ 12,934,871	$ 12,945,500	$ 10,584,698	$ (9,097,316)	$ 14,432,882

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED SCHEDULES OF RELATED PARTY TRANSACTIONS
FOR THE YEAR ENDED MARCH 31
(in thousands)

Related parties are those entities consolidated or accounted for on a modified equity basis in the Province of Alberta's financial statements. Related parties also include management in the Ministry.

The Ministry and its employees paid or collected certain taxes and fees set by regulation for permits, licenses and other charges. These amounts were incurred in the normal course of business, reflect charges applicable to all users, and have been excluded from this Schedule.

The Ministry had the following transactions with related parties recorded in the Consolidated Statements of Operations and Financial Position at the amount of consideration agreed upon between the related parties.

	2010	2009 (Restated - Note 3)
Revenues		
Grants	$ 413,908	$ 279,752
Other	43,433	42,779
	$ 457,341	$ 322,531
Expenses - Directly Incurred		
Grants	$ 94,490	$ 70,882
Other	125,292	123,260
Interest (ACFA)	8,845	6,050
	$ 228,627	$ 200,192
Receivables	$ 6,800	$ 15,046
Payables	$ 14,291	$ 13,934
Debt to related parties e.g. ACFA	$ 176,662	$ 183,820

The Ministry receives services under contracts managed by Service Alberta. Any commitments under these contracts are reported by Service Alberta.

The Ministry also had the following transactions with related parties for which no consideration was exchanged. The amounts for these related party transactions are estimated based on the costs incurred by the service provider to provide the service. These amounts are not recorded in the consolidated financial statements and are disclosed in Schedule 5.

	2010	2009 (Restated - Note 3)
Expenses - Incurred by Others		
Accommodation	$ 45,988	$ 38,709
Legal	2,555	3,058
Other	7,194	7,119
	$ 55,737	$ 48,886

Schedule 5

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED SCHEDULES OF ALLOCATED COSTS
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2010								2009
		Expenses - Incurred by Others			Valuation Adjustments				(Restated - Note 3)
Program	Expenses [1]	Accommodation Costs [2]	Legal Services [3]	Other	Health Care Insurance Premium Recoveries	Other Write-Offs	Vacation Pay	Total	Total
Physician Services	$ 2,573,693	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,573,693	$ 2,315,941
Supplementary Health Benefits	721,683	-	-	-	-	-	-	721,683	670,381
Healthy Living and Wellness	381,584	-	-	-	-	-	-	381,584	354,685
Provincial Programs	171,914	-	-	-	-	-	-	171,914	195,728
Facility Based Patient Care	4,423,799	36,088	-	-	-	-	17,974	4,477,861	4,271,786
Community Based & Home Care	1,058,635	-	-	-	-	-	-	1,058,635	907,853
Diagnostic, Therapeutic & Other Patient Services	2,347,539	-	-	-	-	-	-	2,347,539	1,989,055
Research and Education	237,233	-	-	-	-	-	-	237,233	241,511
Health Service Delivery Support	1,431,930	-	-	-	-	-	-	1,431,930	1,482,866
Administration & Support Services	908,458	9,900	2,555	7,194	-	-	-	928,107	849,463
Health Care Insurance Premium Revenue (Recoveries) / Revenue Write-Offs [4]	-	-	-	-	(14,851)	-	-	(14,851)	82,258
Others	148,765	-	-	-	-	24,526	-	173,291	168,335
	$ 14,405,233	$ 45,988	$ 2,555	$ 7,194	$ (14,851)	$ 24,526	$ 17,974	$ 14,488,619	$ 13,529,862

[1] Expenses - Directly Incurred as per Statement of Operations, excluding valuation adjustments.

[2] Costs shown for Accommodation (includes grants in lieu of taxes) on Schedule 4.

[3] Costs shown for Legal Services on Schedule 4.

[4] Health Care Insurance Premium Revenue (Recoveries) / Write-Offs relate to Premiums and fees revenue.

Schedule 6

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED SCHEDULES OF PORTFOLIO INVESTMENTS
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2010		2009 (Restated - Note 3)	
	Cost	Fair (Market) Value	Cost	Fair (Market) Value
Money Market	$ 92,839	$ 92,845	$ 117,646	$ 118,107
Fixed-income securities:				
Government of Canada, direct and guaranteed	59,503	59,783	59,825	62,689
Provincial - Alberta	1,197	1,233	599	622
Provincial - Other	87,997	88,934	62,905	54,080
Municipal	6,384	6,617	6,132	4,663
Corporate	126,093	130,137	164,767	172,687
Pooled investment funds	16,322	16,715	23,622	30,307
	297,496	303,419	317,850	325,048
Equities:				
Canadian	92,435	112,782	90,315	86,739
Foreign	29,918	28,423	41,966	30,085
Real estate	-	-	76	76
Pooled investment funds	32,257	30,627	45,327	26,479
	154,610	171,832	177,684	143,379
Total	$ 544,945	$ 568,096	$ 613,180	$ 586,534

The majority of Portfolio Investments are held by AHS. In order to earn optimal financial returns at an acceptable level of risk, AHS has established an investment bylaw with maximum asset mix ranges for money market securities, fixed income securities and equities.

a) Interest Rate Risk

The interest rate risk exposure of its fixed income investments is managed by the management of average duration and laddered maturity dates.

Fixed Income securities have an average effective market yield of 3.7 per cent (2009 - 3.00 per cent to 7.39 per cent) per annum and the following maturity structure (in per cent).

	2010	2009
Under 1 Year	6	22
1 to 5 years	39	38
6 to 10 years	31	25
Over 10 years	24	15

b) Currency Risk

AHS is exposed to foreign exchange fluctuations on its investments denominated in foreign currencies. However, this risk is mitigated by the fact that AHS' investment bylaw limits non - Canadian equities to 50 per cent to total equities.

c) Credit and Market Risks

AHS' investment bylaw restricts the type and proportions of eligible investments. Money market investments are limited to a rating of R1 or equivalent or higher and no more than 10 per cent may be invested in any other issuer. Investments in corporate bonds are limited to BBB rated bonds or higher and no more than 40 per cent of the total fixed income investments. No more than 10 per cent may be invested in BBB rated bonds. Equities are comprised of publicly traded securities in major stock markets. Investment in debt and equity of any issuer are limited to 5 per cent of the issuer's total debt and equity. Short selling is not permitted.

Financial Information

Department of Health and Wellness

Financial Statements

March 31, 2010

Department of Health and Wellness

Financial Statements

March 31, 2010

DEPARTMENT OF HEALTH AND WELLNESS

FINANCIAL STATEMENTS

MARCH 31, 2010

Auditor's Report

Statements of Operations

Statements of Financial Position

Statements of Cash Flows

Notes to the Financial Statements

Schedule 1 - Revenues

Schedule 2 - Credit or Recovery Initiatives

Schedule 3 - Expenses Directly Incurred Detailed by Object

Schedule 4 - Budget

Schedule 5 - Comparison of Expenses - Directly Incurred, Equipment/Inventory Purchases and Capital Investment by Element to Authorized Budget

Schedule 6 - Salaries and Benefits

Schedule 7 - Related Party Transactions

Schedule 8 - Allocated Costs

AUDITOR GENERAL
Alberta

Auditor's Report

To the Minister of Health and Wellness

I have audited the statements of financial position of the Department of Health and Wellness as at March 31, 2010 and 2009 and the statements of operations and cash flows for the years then ended. These financial statements are the responsibility of the Department's management. My responsibility is to express an opinion on these financial statements based on my audits.

I conducted my audits in accordance with Canadian generally accepted auditing standards. Those standards require that I plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In my opinion, these financial statements present fairly, in all material respects, the financial position of the Department as at March 31, 2010 and 2009 and the results of its operations and its cash flows for the years then ended in accordance with Canadian generally accepted accounting principles.

[Original signed by Merwan N. Saher]

CA
Auditor General

Edmonton, Alberta
June 11, 2010

DEPARTMENT OF HEALTH AND WELLNESS
STATEMENTS OF OPERATIONS
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2010		2009
	Budget (Schedule 4)	Actual	Actual (Restated - Note 3)
Revenues (Schedule 1)			
Internal Government Transfers	$ 417,034	$ 413,908	$ 279,752
Transfers from Government of Canada	2,036,429	2,329,159	2,050,857
Investment Income	32,000	11,944	35,891
Premiums, Fees and Licences	34,190	42,567	784,820
Other Revenue	96,646	120,155	176,557
	2,616,299	2,917,733	3,327,877
Expenses - Directly Incurred (Note 2b(vi) and Schedule 8)			
Voted (Schedules 3 and 5)			
Ministry Support Services	191,888	146,263	171,316
Physician Services	3,001,347	2,891,122	2,600,795
Provincial Programs	1,672,558	1,489,086	1,527,333
Healthy Living and Wellness	90,026	61,361	87,679
Health Authority Services	7,714,197	8,055,854	7,530,769
Infrastructure Support	237,855	210,534	857,907
H1N1 Pandemic Response (Note 4)	-	80,156	-
	12,907,871	12,934,376	12,775,799
Statutory (Schedules 3 and 5)			
Cancer Research and Prevention Investment	25,000	21,874	19,257
Valuation Adjustments			
Health Care Insurance Premium Revenue (Recoveries)/Write-Offs	-	(14,851)	82,258
Other Write-Offs	2,000	3,977	272
Provision for Vacation Pay	-	124	533
	27,000	11,124	102,320
Total Voted and Statutory Expenses	12,934,871	12,945,500	12,878,119
Write-down of Inventory	-	11,321	-
Net Operating Results	$ (10,318,572)	$ (10,039,088)	$ (9,550,242)

The accompanying notes and schedules are part of these financial statements

DEPARTMENT OF HEALTH AND WELLNESS
STATEMENTS OF FINANCIAL POSITION
AS AT MARCH 31
(in thousands)

	2010	2009 (Restated - Note 3)
ASSETS		
Cash	$ 1,511	$ 3,495
Accounts Receivable (Note 5)	79,066	60,132
Tangible Capital Assets (Note 6)	89,604	91,265
Consumable Inventory	18,776	27,125
	$ 188,957	$ 182,017
LIABILITIES		
Accounts Payable and Accrued Liabilities (Note 7)	$ 469,881	$ 794,194
Unearned Revenue (Note 8)	26,899	61,713
	496,780	855,907
NET LIABILITIES		
Net Liabilities at Beginning of Year	(673,890)	(1,319,616)
Net Operating Results	(10,039,088)	(9,550,242)
Net Financing provided from General Revenues	10,405,155	10,195,968
Net Liabilities at End of Year	(307,823)	(673,890)
	$ 188,957	$ 182,017

The accompanying notes and schedules are part of these financial statements

DEPARTMENT OF HEALTH AND WELLNESS
STATEMENTS OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2010	2009 (Restated - Note 3)
Operating Transactions		
Net Operating Results	$ (10,039,088)	$ (9,550,242)
Non-cash items:		
Amortization (Note 6)	24,569	18,121
Valuation Adjustments and write-downs	15,422	83,063
	(9,999,097)	(9,449,058)
(Increase)/Decrease in Accounts Receivable	(22,911)	93,024
(Increase) in Consumable Inventory	(2,972)	(6,245)
(Decrease) in Accounts Payable and Accrued Liabilities	(324,437)	(719,090)
(Decrease) in Unearned Revenue	(34,814)	(104,091)
Cash (applied to) Operating Transactions	(10,384,231)	(10,185,460)
Capital Transactions		
Acquisition of Tangible Capital Assets (Note 6)	(22,908)	(31,146)
Cash (applied to) Capital Transactions	(22,908)	(31,146)
Financing Transactions		
Net Financing provided from General Revenues	10,405,155	10,195,968
Decrease in Cash	(1,984)	(20,638)
Cash, Beginning of Year	3,495	24,133
Cash, End of Year	$ 1,511	$ 3,495

The accompanying notes and schedules are part of these financial statements

DEPARTMENT OF HEALTH AND WELLNESS
NOTES TO THE FINANCIAL STATEMENTS
MARCH 31

Note 1 Authority and Purpose

The Department of Health and Wellness (the Department) operates under the authority of the *Government Organization Act*, Chapter G-10, Revised Statutes of Alberta 2000.

The purpose of the Department is to maintain and improve the health of Albertans by providing increased access to quality health care and improve the efficiency and effectiveness of health care service delivery. The Department is also engaged in inter-ministerial initiatives to effectively address challenges to the health and well-being of the population.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

These financial statements are prepared in accordance with Canadian generally accepted accounting principles for the public sector as recommended by the Public Sector Accounting Board (PSAB) of the Canadian Institute of Chartered Accountants. The PSAB financial statements presentation standard for government summary financial statements has been modified to more appropriately reflect the nature of the department (see note 2(a) below).

(a) Reporting Entity

The reporting entity is the Department of Health and Wellness, which is part of the Ministry of Health and Wellness and for which the Minister of Health and Wellness is accountable.

Other entities reporting to the Minister are Alberta Health Services (AHS) and its controlled entities, and the Health Quality Council of Alberta (HQCA). The financial results of these organizations are not included in these financial statements.

The Ministry Annual Report provides a comprehensive accounting of the financial position and results of the Ministry's operations for which the Minister is accountable.

All departments of the Government of Alberta operate within the General Revenue Fund (the Fund). The Fund is administered by the Minister of Finance and Enterprise. All cash receipts of departments are deposited into the Fund and all cash disbursements made by departments are paid from the Fund. Net Financing provided from General Revenues is the difference between all cash receipts and all cash disbursements made.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Basis of Financial Reporting

(i) Revenues

All revenues are reported on the accrual basis of accounting. Cash received for which goods or services have not been provided by year end is recorded as unearned revenue.

(ii) Internal Government Transfers

Internal government transfers are transfers between entities within the government reporting entity where the entity making the transfer does not receive any goods or services directly in return. Internal government transfers are recognized as revenue when received.

(iii) Transfers from Government of Canada

Transfers from Government of Canada are recognized as revenues when authorized by federal legislation or federal/provincial agreements, eligibility criteria, if any, are met and a reasonable estimate of the amounts can be made. Overpayments relating to Canada Health Transfers entitlements and other transfers received before revenue recognition criteria have been met are included in either accounts payable and accrued liabilities or unearned revenue.

(iv) Investment Income

Under the terms of the capital funding arrangement with AHS, the capital funding from the Department is deposited into the consolidated cash and investment trust fund (CCITF) of the Province of Alberta until AHS needs funds to make payments for the construction of approved capital projects. The CCITF is managed with the objective of providing competitive interest income to depositors. The interest income earned on funds held in the CCITF is deposited into the General Revenue Fund.

(v) Credit or Recovery

Credit or recovery initiatives provide a basis for authorizing spending. Credit or recovery is shown in the details of the Government Estimates for a supply vote.

If budgeted revenues are not fully realized, spending is reduced by an equivalent amount. If actual credit or recovery revenues exceed budget, the Department may, with the approval of the Treasury Board, use the excess revenue to fund additional expenses of the program. Schedule 2 discloses information on the Department's credit or recovery initiatives.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Basis of Financial Reporting (continued)

(vi) Expenses

Directly Incurred

Directly incurred expenses are those costs the Department has primary responsibility and accountability for, as reflected in the Government's budget documents.

In addition to program operating expenses such as grants, salaries, supplies etc., directly incurred expenses also include:

- amortization of tangible capital assets.
- inventory consumed.
- pension costs, which are the cost of employer contributions during the year.
- valuation adjustments which include changes in the valuation allowances used to reflect financial assets at their net recoverable or other appropriate value. Valuation adjustments also represent the change in management's estimate of future payments arising from obligations relating to vacation pay.

Grants are recognized as expenses when authorized, eligibility criteria, if any, are met, and a reasonable estimate of the amounts can be made.

Incurred by Others

Services contributed by other entities in support of the Department's operations are not recognized and are disclosed in Schedule 7 and Schedule 8.

(vii) Assets

Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations. Financial assets of the Department are limited to cash and financial claims, such as advances to and receivables from other organizations, employees and other individuals.

Assets acquired by right are not included. Tangible capital assets of the Department are recorded at historical cost which includes all amounts directly attributable to the acquisition, construction, development or betterment of the asset. Tangible capital assets are amortized on a straight-line basis over the estimated useful lives of the assets. The threshold for capitalizing new systems development is $250,000 and the threshold for major enhancements is $100,000. The threshold for all other tangible capital assets is $5,000. All land is capitalized.

Consumable inventory is valued at the lower of cost and replacement cost and is determined on a first-in, first-out basis.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Basis of Financial Reporting (continued)

(viii) Liabilities

Liabilities are recorded to the extent that they represent present obligations as a result of events and transactions occurring prior to the end of fiscal year. The settlement of liabilities will result in sacrifice of economic benefits in the future.

(ix) Net Liabilities

Net liabilities represent the difference between the carrying value of assets held by the Department and its liabilities.

(x) Valuation of Financial Assets and Liabilities

Fair value is the amount of consideration agreed upon in an arm's length transaction between knowledgeable, willing parties who are under no compulsion to act.

The fair values of cash, accounts receivable, accounts payable and accrued liabilities are estimated to approximate their carrying values because of the short term nature of these instruments.

(xi) Payments under Reciprocal and Other Agreements

The Department entered into agreements with other Provincial and Territorial Governments, the Federal Government, the Royal Canadian Mounted Police and the Workers' Compensation Board to provide services on their behalf.

Expenses incurred and revenue earned in the provision of services under these agreements are recorded in the records of the service providers and are not included in these financial statements. Amounts paid and recovered under these agreements are disclosed in Note 11.

(xii) Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. Measurement uncertainty that is material to these financial statements exists in the accrual of Canada Health Transfer. The nature of uncertainty for Canada Health Transfers can arise from changes in the base allocations which are primarily a result of updated personal and corporate tax information or from a new entitlement with little historical experience.

Note 3 Reporting Changes
(in thousands)

As a result of transfer of responsibility for programs between the Department of Health and Wellness and the Department of Infrastructure and the Department of Seniors and Community Support, the comparatives for 2008/2009 have been restated as if the respective Departments had always been assigned with its current responsibilities.

The following is a summary of the effect of the reporting changes on the 2008/2009 financial statements:

	March 31, 2009			
		Reporting Changes		
	As Previously Reported	Transfers from Infrastructure [1]	Transfers to Seniors and Community Support [2]	As Restated
Revenues	$ 3,327,877	$ -	$ -	$ 3,327,877
Expenses	12,883,319	248	(5,448)	12,878,119
Net Operating Results	(9,555,442)	(248)	5,448	(9,550,242)
Net Financing provided from General Revenues	10,201,168	248	(5,448)	10,195,968
Net Liabilities at March 31, 2008	(1,319,616)	-	-	(1,319,616)
Net Assets Liabilities at March 31, 2009	$ (673,890)	$ -	$ -	$ (673,890)

[1] Responsibility for the operational funding for a health facility was transferred from the Department of Infrastructure to the Department of Health and Wellness.

[2] Responsibility for Supplementary Health Benefits for Alberta Aids to Daily Living was transferred to the Department of Seniors and Community Support.

Note 4 H1N1 Pandemic Response
(in thousands)

	2010	2009
Funding for Alberta Health Services	$ 58,700	$ -
Physician Compensation	15,696	-
Vaccines dispensed	5,760	-
	80,156	-
Write-down of expired vaccines	4,678	-
	$ 84,834	$ -

Note 5 Accounts Receivable
(in thousands)

	2010			2009
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Accounts Receivable	$ 89,946	$ (13,628)	$ 76,318	$ 55,744
Amounts due from AHS and HQCA	1,780	-	1,780	3,501
Other Receivable	968	-	968	887
	$ 92,694	$ (13,628)	$ 79,066	$ 60,132

Note 6 Tangible Capital Assets
(in thousands)

	2010			2009
	Equipment	Computer Hardware and Software	Total	Total
Estimated Useful Life	10 years	5 - 10 years		
Historical Cost[1]				
Beginning of year	$ 2,347	$ 166,513	$ 168,860	$ 137,714
Additions	22	22,886	$ 22,908	31,146
Disposals, including Write-downs	-	(17,074)	$ (17,074)	-
	2,369	172,325	174,694	168,860
Accumulated Amortization				
Beginning of year	$ 751	$ 76,844	$ 77,595	$ 59,474
Amortization expense	238	24,331	$ 24,569	18,121
Effect of disposals	-	(17,074)	$ (17,074)	-
	989	84,101	85,090	77,595
Net Book Value at March 31, 2010	$ 1,380	$ 88,224	$ 89,604	
Net Book Value at March 31, 2009	$ 1,596	$ 89,669		$ 91,265

[1] Historical cost includes work-in-progress at March 31, 2010 for computer hardware and software totaling $20,236 (2009 - $1,924).

Note 7 Accounts Payable and Accrued Liabilities
(in thousands)

	2010	2009
Accounts payable	$ 124,193	$ 452,975
Accrued liabilities	255,447	289,370
Amounts due to AHS and HQCA	82,689	44,422
Accrued vacation pay	7,552	7,427
	$ 469,881	$ 794,194

Note 8 Unearned Revenue
(in thousands)

Changes in unearned revenues are as follows:

	2010	2009
Cash received/receivable during the year:		
Supplementary Health Benefits Premiums	$ 3,269	$ 2,117
Health Services for Persons with Hepatitis C	5,200	-
Human Papillomavirus	-	31,178
	8,469	33,295
Less amounts recognized as revenue in the year	(43,283)	(137,386)
Decrease during the year	(34,814)	(104,091)
Balance at beginning of year	61,713	165,804
Balance at end of year	$ 26,899	$ 61,713
Balances at end of year are comprised of:		
Supplementary Health Benefits Premiums	$ 3,269	$ 2,117
Health Services for Persons with Hepatitis C	6,891	4,857
Third Party Recoveries	15	19
Patient Wait Times Guarantee	-	30,976
Human Papillomavirus	16,724	23,744
	$ 26,899	$ 61,713

Note 9 Contractual Obligations
(in thousands)

Contractual Obligations are obligations of the department to others that will become liabilities in future when the terms of those contracts or agreements are met. As at March 31, 2010, the Department has the following contractual obligations:

	2010	2009
Specific programs commitments	$ 554,209	$ 1,044,269
Capital and construction contracts	5,432,627	2,431,810
Service contracts	72,275	96,246
	$ 6,059,111	$ 3,572,325

The aggregate amounts payable for the unexpired terms of these contractual obligations are as follows:

	Specific Programs Commitments	Capital & Construction Contracts	Service Contracts	Total 2010
2011	$ 520,106	$ 676,163	$ 57,368	$ 1,253,637
2012	17,767	787,639	7,298	812,704
2013	4,084	630,587	6,832	641,503
2014	4,084	487,363	611	492,058
2015	4,084	735,721	13	739,818
Thereafter	4,084	2,115,154	153	2,119,391
	$ 554,209	$ 5,432,627	$ 72,275	$ 6,059,111

Canadian Blood Services (CBS)

The Government of Alberta is committed to provide funding to Canadian Blood Services (CBS) for the provision of blood services in Alberta. This commitment was outlined in a Memorandum of Understanding, signed in January 1998, which recorded the understandings and commitments of the Minister of Health of Canada and the Provincial and Territorial Ministers of Health (except Quebec) regarding their respective roles and responsibilities in a renewed national blood system.

The Province's obligation for the operational costs of CBS is determined on a per capita basis, and the costs for fractionated blood and blood products is determined on the basis of annual utilization of these products. During the year, payments to CBS amounted to $156,274 (2009 - $140,175). Budgeted expenditure for the 2011 fiscal year is $162,702.

Note 10 Contingencies, Equity Agreements with Voluntary Hospital Owners and Indemnity
(in dollars)

Hepatitis C

In June 1999, the Federal, provincial and territorial governments entered into an agreement to provide financial assistance to Canadians who were affected by the Hepatitis C virus through the Canadian blood system during the period from January 1, 1986 to July 1, 1990. The agreement provided for a total federal, provincial and territorial contribution of $1.1 billion plus interest. Interest is calculated and accrued quarterly on the outstanding balance at a rate equal to the 3 month Government of Canada Treasury Bill rate for the quarter. In the fiscal year 1999/2000, the Department accrued $30 million; representing Alberta's estimated proportionate share of the financial assistance, excluding accrued interest. At March 31, 2010, the outstanding unpaid balance, including Alberta's proportionate share of the accrued interest, was $17.7 million (2009 - $17.9 million).

Equity Agreements with Voluntary Hospital Owners

The Department has a contingent liability for buy-out of equity under Equity Agreements entered into between the Department and Voluntary Hospital Owners. The Department's payout liability is contingent upon notification by the voluntary hospital owner of termination of the equity agreement. At March 31, 2010, the contingent payout liability upon termination is estimated at $12.8 million (2009 - $12.8 million).

Other Contingencies

At March 31, 2010, the Department was named as defendant in 22 legal actions, the outcome of which is indeterminable (2009 - 19 legal actions). 18 of these claims have specified amounts totaling $430.6 million and the remaining 4 have no specified amounts (2009 - 16 claims with a specified amount of $1,209.0 million and 3 with no specified amount). Included in the total legal actions are 17 claims amounting to $392.4 million (2009 - 15 claims amounting to $1,170.8 million) in which the Department has been jointly named with other entities and individuals. 9 claims amounting to $6.7 million (2009 - 4 claims amounting to $6.9 million) are covered by the Alberta Risk Management Fund. 2 claims amounting to $205.9 million (2009 - 1 claim amounting to $404.7 million) are partially covered by Alberta Risk Management Fund. The resulting loss, if any, from these claims cannot be determined.

Indemnity

As described in Note 9, CBS provides blood services in Alberta. CBS has established two wholly-owned captive insurance corporations, CBS Insurance Company Limited (CBSI) and Canadian Blood Services Captive Insurance Company Limited (CBSE). CBSI provides insurance coverage up to $250.0 million with respect to risks associated with the operation of the blood system.

Effective September 28, 2006, CBSE has entered into an agreement whereby the provinces (except Quebec) and territories guarantee and indemnify the risks of operation of the blood system in the amount of $750.0 million in excess of the $250.0 million provided by the insurance coverage from CBSI. Alberta's Pro Rata Share of the $750.0 million is 13.1% or $98.0 million. Authority for Alberta to provide the indemnity under the CSA is pursuant to section 5.05 of the Indemnity Authorization Regulation 22/1997, under the *Financial Administration Act*.

The expense recognition criterion for the indemnity is notification from the CBS that the indemnity is required. At March 31, 2010, no amount has been recognized for this indemnity.

Note 11 Payments under Reciprocal and Other Agreements
(in thousands)

The Department entered into agreements, under the Alberta Health Care Insurance Plan, with other Provincial and Territorial Governments and the Royal Canadian Mounted Police (RCMP) to provide health services on their behalf. The Department pays service providers for services rendered under the agreements and recovers the amount paid from other provinces and the RCMP. Service providers include Alberta Health Services and physicians.

The Department also entered into agreements with the Western Provinces and Territories for the Western Health Information Collaborative (WHIC) to explore common opportunities that would meet their health information needs and support the strategic directions and initiatives for health infrastructure at the national level.

In addition, the Department entered into agreements with Health Canada, the Workers' Compensation Board and other provincial and territorial governments to provide air ambulance services on their behalf. Payments incurred under these agreements are made by the Department under authority of the *Financial Administration Act*, Section 25 (1).

Alberta undertook the role as lead jurisdiction for the National Blood portfolio for the period May 1, 2008 to March 31, 2010. The primary focus of this role was to provide secretariat functions for the activities and initiatives of the Provincial/Territorial Blood Liaison Committee to CBS. The Provincial/Territorial Collaborative Initiative Fund supports the activities of the lead jurisdiction.

Balances receivable from or payable to the Federal Government, other provincial and territorial Governments and the RCMP are reflected in the Statement of Financial Position.

	2010					2009
	Western Health Information Collaborative	Other Provincial, Territorial Govt & RCMP	Air Ambulance	Collaborative Initiative Fund	Total	Total
Opening receivable (payable) balance	$ 38	$ 38,004	$ 935	$ (458)	$ 38,519	$ 54,383
Add: Payments made during the year	-	217,436	3,353	299	221,088	240,965
	38	255,440	4,288	(159)	259,607	295,348
Less: Collections received during the year	-	(221,519)	(3,389)	(250)	(225,158)	(256,678)
Less: Adjustments made during the year	-	-	(1)	-	(1)	(151)
Closing receivable (payable) balance	$ 38	$ 33,921	$ 898	$ (409)	$ 34,448	$ 38,519

Note 12 Benefit Plans
(in thousands)

The Department participates in the multi-employer pension plans, Management Employees Pension Plan and Public Service Pension Plan. The Department also participates in the multi-employer Supplementary Retirement Plan for Public Service Managers. The expense for these pension plans is equivalent to the annual contributions of $7,088 for the year ended March 31, 2010 (2009 - $6,319).

At December 31, 2009, the Management Employees Pension Plan reported a deficiency of $483,199 (2008 - $568,574) and the Public Service Pension Plan reported a deficiency of $1,729,196 (2008 - $1,187,538). At December 31, 2009, the Supplementary Retirement Plan for Public Service Managers had a deficiency of $39,516 (2008 - $7,111).

The Department also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2010, the Bargaining Unit Plan reported an actuarial deficiency of $8,335 (2009 - $33,540) and the Management, Opted Out and Excluded Plan an actuarial surplus of $7,431 (2009 - deficiency of $1,051). The expense for these two plans is limited to the employer's annual contribution for the year.

Note 13 Comparative Figures

Certain 2009 figures have been reclassified, where necessary, to conform to the 2010 presentation.

Note 14 Subsequent Events

Effective April 1, 2010, the responsibility for Health Facilities Infrastructure will be transferred over to the Department of Infrastructure.

Note 15 Approval of Financial Statements

The financial statements were approved by the Senior Financial Officer and the Deputy Minister.

Schedule 1

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULES OF REVENUES
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2010		2009
	Budget (Schedule 4)	Actual	Actual
Internal Government Transfers			
Transfer from the Lottery Fund	$ 392,034	$ 392,034	$ 260,495
Transfer from Alberta Cancer Prevention Legacy Fund	25,000	21,874	19,257
	417,034	413,908	279,752
Transfers from Government of Canada			
Canada Health Transfer	1,961,782	2,260,243	1,947,239
Wait Times Reduction	26,956	27,316	61,222
Other Health Transfers	47,691	41,600	42,396
	2,036,429	2,329,159	2,050,857
Investment Income	32,000	11,944	35,891
Premiums, Fees and Licenses			
Health Care Insurance Premiums [1]	-	-	758,707
Supplementary Health Benefit Premiums	34,000	42,305	25,904
Other	190	262	209
	34,190	42,567	784,820
Other Revenue			
Third Party Recoveries	94,300	93,187	90,000
Previous years' refunds of expenditure	-	20,520	80,129
Miscellaneous	2,346	6,448	6,428
	96,646	120,155	176,557
Total revenue	$ 2,616,299	$ 2,917,733	$ 3,327,877

[1] Health Care Insurance Premiums have been eliminated effective January 1, 2009.

Schedule 2

DEPARTMENT OF HEALTH & WELLNESS
SCHEDULE OF CREDIT OR RECOVERY INITIATIVES
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2010		
	Authorized Credit or Recovery	Actual Credit or Recovery [a]	(Shortfall) / Excess
Ministry Support Services			
Strategic Policy and System Development [b]	$ 100	$ 72	$ (28)
Public Health [c]	572	263	(309)
Provincial Programs			
Support Programs [d]	4,542	3,516	(1,026)
	$ 5,214	$ 3,851	$ (1,363) [e]

(a) Revenues from credit or recovery initiatives are included in the Department's revenues in the Statements of Operations.

(b) The Department provides statistical information and reports to third party researchers and institutions.

(c) The Department receives funding from Health Canada to support development of a National Diabetes Surveillance system.

(d) The Department receives funding from Health Canada to enhance existing health services to persons with chronic Hepatitis C virus infection. Funding is also received from drug companies for specific studies or programs that contribute to cost-effective use of medications.

(e) Shortfall is deducted from current year's authorized budget, as disclosed in Schedules 4 and 5 to the financial statements.

Schedule 3

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULES OF EXPENSES DIRECTLY INCURRED DETAILED BY OBJECT
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2010		2009
	Budget	Actual	Actual (Restated - Note 3)
Voted:			
Grants	$ 12,625,680	$ 12,690,916	$ 12,526,805
Supplies and Services	130,252	100,723	124,212
Salaries, Wages and Employee Benefits	76,096	74,364	73,867
Amortization	29,979	24,569	18,121
Inventory Consumed	45,751	43,674	32,690
Other	113	130	104
Total Voted Expenses	$ 12,907,871	$ 12,934,376	$ 12,775,799
Statutory:			
Cancer Research and Prevention Investment	$ 25,000	$ 21,874	$ 19,257
Valuation Adjustments			
Health Care Insurance Premium Revenue (Recoveries)/Write-Offs	-	(14,851)	82,258
Other Write-offs	2,000	3,977	272
Provision for Vacation Pay	-	124	533
	$ 27,000	$ 11,124	$ 102,320

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULE OF BUDGET
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2009 - 2010 Estimates	Adjustments (a)	2009-2010 Budget	Authorized Supplementary (b)	2009 - 2010 Authorized Budget
Revenues:					
Internal Government Transfers	$ 417,034	$ -	$ 417,034	$ -	$ 417,034
Transfer from Government of Canada	2,036,429	-	2,036,429	-	2,036,429
Investment Income	32,000	-	32,000	-	32,000
Premiums and Fees	34,190	-	34,190	-	34,190
Other Revenue	96,646	-	96,646	-	96,646
	2,616,299	-	2,616,299	-	2,616,299
Expenses - Directly Incurred:					
Voted Expenses					
Ministry Support Services	191,888	-	191,888	(9,076)	182,812
Physician Services	3,001,347	-	3,001,347	(68,532)	2,932,815
Provincial Programs	1,672,558	-	1,672,558	(146,070)	1,526,488
Healthy Living and Wellness	90,026	-	90,026	(4,697)	85,329
Health Authority Services	7,714,197	-	7,714,197	343,000	8,057,197
Infrastructure Support	237,855	3,343	241,198	(30,700)	210,498
H1N1 Pandemic Response	-	-	-	148,866	148,866
Credit or Recovery Shortfall (Schedule 2)	-	(1,363)	(1,363)	-	(1,363)
	12,907,871	1,980	12,909,851	232,791	13,142,642
Statutory Expenses					
Cancer Research and Prevention Investment	25,000	-	25,000	-	25,000
Valuation Adjustments					
Health Care Insurance Premium Revenue Write-Offs	-	-	-	-	-
Other Write-offs	2,000	-	2,000	-	2,000
Provision for Vacation Pay		-	-	-	-
	27,000	-	27,000	-	27,000
Total Expense	12,934,871	1,980	12,936,851	232,791	13,169,642
Net Operating Results	$ (10,318,572)	$ (1,980)	$(10,320,552)	$ (232,791)	$(10,553,343)
Equipment / Inventory Purchases	$ 54,600	$ -	$ 54,600	$ 10,400	$ 65,000
Capital Investment	$ 19,200	$ -	$ 19,200	$ -	$ 19,200

(a) Adjustments include encumbrances and credit or recovery shortfalls. The increase is as a result of transfer of $3,343 for emerging capital projects from the Department of Infrastructure pursuant to section 5 and 5(1) of the Appropriation Act, 2009.

(b) Supplementary estimates were approved on March 1, 2010. Treasury Board approval is pursuant to section 24(2) of the Financial Administration Act.

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULE TO FINANCIAL STATEMENTS
Comparison of Expenses - Directly Incurred, Equipment / Inventory Purchases and Capital Investment by Element to Authorized Budget
For the Year Ended March 31, 2010
(in thousands)

Voted Expenses, Equipment/Inventory Purchases and Capital Investment:	2009/2010 Estimates	Adjustments [a]	2009/2010 Budget	Authorized Supplementary [b]	2009/2010 Authorized Budget	2009/2010 Actual [c]	Unexpended / (Over Expended)
Ministry Support Services							
1.0.1 Minister's Office	$ 548	$ -	$ 548	$ -	$ 548	$ 539	$ 9
1.0.2 Deputy Minister's Office	711	-	711	-	711	1,070	(359)
1.0.3 Public Communications	1,852	-	1,852	-	1,852	1,696	156
1.0.4 Strategic Policy and System Development	16,589	-	16,589	-	16,589	12,390	4,199
1.0.5 Public Health	22,648	-	22,648	-	22,648	13,606	9,042
1.0.6 Workforce Services	10,366	-	10,366	-	10,366	9,840	526
1.0.7 Corporate Support Services							
- Expense	115,438	-	115,438	(9,076)	106,362	84,110	22,252
- Equipment/Inventory Purchases	-	-	-	-	-	12	(12)
1.0.8 Program Services							
- Expense	19,123		19,123	-	19,123	19,151	(28)
- Equipment/Inventory Purchases	-	-	-		-	9	(9)
1.0.9 Health Facilities Review Committee	884	-	884	-	884	735	149
1.0.10 Health Advisory and Appeal Services	2,503	-	2,503	-	2,503	2,480	23
1.0.11 Mental Health Patient Advocate Office	1,226	-	1,226	-	1,226	645	581
Total Ministry Support Services	191,888	-	191,888	(9,076)	182,812	146,283	36,529
Physician Services							
2.0.1 Physician Compensation	2,557,429	-	2,557,429	7,100	2,564,529	2,554,026	10,503
2.0.2 On Call Programs	87,150	-	87,150	(2,000)	85,150	86,150	(1,000)
2.0.3 Physician Office System Program	65,100	-	65,100	(20,100)	45,000	31,159	13,841
2.0.4 Primary Care	157,050	-	157,050	(25,100)	131,950	123,155	8,795
2.0.5 Academic Alternate Relationship Plans	125,392	-	125,392	(28,432)	96,960	87,406	9,554
2.0.6 Rural Physician Action Plan	9,226	-	9,226	-	9,226	9,226	-
Total Physician Services	3,001,347	-	3,001,347	(68,532)	2,932,815	2,891,122	41,693

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULE TO FINANCIAL STATEMENTS
Comparison of Expenses - Directly Incurred, Equipment / Inventory Purchases and Capital Investment by Element to Authorized Budget
For the Year Ended March 31, 2010
(in thousands)

Voted Expenses, Equipment/Inventory Purchases and Capital Investment:	2009/2010 Estimates	Adjustments [a]	2009/2010 Budget	Authorized Supplementary [b]	2009/2010 Authorized Budget	2009/2010 Actual [c]	Unexpended / (Over Expended)
Provincial Programs							
3.0.1 Supplementary Health Benefits	$ 767,753	$ -	$ 767,753	$ (52,842)	$ 714,911	$ 721,683	$ (6,772)
3.0.2 Allied Health Services	57,738	-	57,738	5,800	63,538	59,872	3,666
3.0.3 Human Tissue and Blood Services							
- Expense	23,300	-	23,300	9,100	32,400	31,323	1,077
- Expense funded by Lotteries	125,000	-	125,000	-	125,000	125,000	-
3.0.4 Air Ambulance Services	38,018	-	38,018	(5,409)	32,609	30,942	1,667
3.0.5 Municipal Ambulance Program	-	-	-	-	-	-	-
3.0.6 Out-of-Province Health Care Services	93,410	-	93,410	7,050	100,460	101,564	(1,104)
3.0.7 Health Information Systems							
- Expense	98,111	-	98,111	(34,619)	63,492	53,796	9,696
- Equipment / Inventory Purchases	10,800	-	10,800	-	10,800	8,891	1,909
- Capital Investment	19,200	-	19,200	-	19,200	13,996	5,204
3.0.8 Health Services Research	3,785	-	3,785	-	3,785	3,535	250
3.0.9 Support to the Health Quality Council of Alberta	4,026	-	4,026	-	4,026	4,026	-
3.0.10 Academic Health Centres	20,751	-	20,751	-	20,751	20,751	-
3.0.11 Medical Resident Allowances	100,892	-	100,892	(5,114)	95,778	98,278	(2,500)
3.0.12 Continuing Care Initiatives	40,700	-	40,700	(29,500)	11,200	9,402	1,798
3.0.13 Safe Communities	42,098	-	42,098	-	42,098	33,028	9,070
3.0.14 Cancer Therapy Drugs	93,600	-	93,600	-	93,600	90,000	3,600
3.0.15 Specialized High Cost Drugs	66,860	-	66,860	-	66,860	64,500	2,360
3.0.16 Support Programs	96,516	-	96,516	(40,536)	55,980	41,386	14,594
Total Provincial Programs	1,702,558	-	1,702,558	(146,070)	1,556,488	1,511,973	44,515

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULE TO FINANCIAL STATEMENTS
Comparision of Expenses - Directly Incurred, Equipment / Inventory Purchases and Capital Investment by Element to Authorized Budget
For the Year Ended March 31, 2010
(in thousands)

Voted Expenses, Equipment/Inventory Purchases and Capital Investment:	2009/2010 Estimates	Adjustments [a]	2009/2010 Budget	Authorized Supplementary [b]	2009/2010 Authorized Budget	2009/2010 Actual [c]	Unexpended / (Over Expended)
Healthy Living and Wellness							
4.0.1 Vaccines and Sera							
- Expense	$ 34,419	$ -	$ 34,419	$ 4,028	$ 38,447	$ 40,234	$ (1,787)
- Equipment / Inventory Purchases	43,800	-	43,800	-	43,800	36,080	7,720
4.0.2 Aboriginal Health Strategies	1,700	-	1,700	-	1,700	250	1,450
4.0.3 Community-Based Health Services							
- Expense	43,907	-	43,907	(8,725)	35,182	10,877	24,305
- Expense funded by Lotteries	10,000	-	10,000	-	10,000	10,000	-
Total Healthy Living and Wellness	133,826	-	133,826	(4,697)	129,129	97,441	31,688
Health Authority Services							
5.0.1 Alberta Health Services							
- Expense	7,457,163	-	7,457,163	-	7,457,163	7,455,820	1,343
- Expense funded by Lotteries	257,034	-	257,034	-	257,034	257,034	-
5.0.2 One-Time Operating Funding	-	-	-	343,000	343,000	343,000	-
Total Health Authority Services	7,714,197	-	7,714,197	343,000	8,057,197	8,055,854	1,343
Infrastructure Support							
6.0.1 Health Facilities Infrastructure	237,855	3,343	241,198	(113,700)	127,498	127,534	(36)
6.0.2 Diagnostic / Medical Equipment	-	-	-	83,000	83,000	83,000	-
Total Infrastructure Support	237,855	3,343	241,198	(30,700)	210,498	210,534	(36)
H1N1 Pandemic Response							
7.0.1 Funding for Alberta Health Services	-	-	-	116,400	116,400	58,700	57,700
7.0.2 Physician Compensation	-	-	-	22,066	22,066	15,696	6,370
7.0.3 Vaccines							
- Expense	-	-	-	10,400	10,400	5,760	4,640
- Equipment / Inventory Purchases	-	-	-	10,400	10,400	10,567	(167)
Total H1N1 Pandemic Response	-	-	-	159,266	159,266	90,723	68,543

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULE TO FINANCIAL STATEMENTS
Comparison of Expenses - Directly Incurred, Equipment / Inventory Purchases and Capital Investment by Element to Authorized Budget
For the Year Ended March 31, 2010
(in thousands)

Voted Expenses, Equipment / Inventory Purchases and Capital Investment:	2009/2010 Estimates	Adjustments [a]	2009/2010 Budget	Authorized Supplementary [b]	2009/2010 Authorized Budget	2009/2010 Actual [c]	Unexpended / (Over Expended)
Credit or Recovery Shortfall (Schedule 2)	$ -	$ (1,363)	$ (1,363)	$ -	$ (1,363)	$ -	$ (1,363)
Total Voted	12,981,671	1,980	12,983,651	243,191	13,226,842	13,003,931	222,911
Expense	12,515,837	1,980	12,517,817	232,791	12,750,608	12,542,342	208,266
Expense funded by lotteries	392,034	-	392,034	-	392,034	392,034	-
	12,907,871	1,980	12,909,851	232,791	13,142,642	12,934,376	208,266
Equipment/Inventory Purchases	54,600	-	54,600	10,400	65,000	55,559	9,441
	12,962,471	1,980	12,964,451	243,191	13,207,642	12,989,935	217,707
Capital Investment	19,200	-	19,200	-	19,200	13,996	5,204
Total Voted - Expenses, Equipment/Inventory Purchases & Capital Investment	$ 12,981,671	$ 1,980	$ 12,983,651	$ 243,191	$ 13,226,842	$ 13,003,931	$ 222,911
Statutory Expenses:							
Cancer Research and Prevention Investment	$ 25,000	$ -	$ 25,000	$ -	$ 25,000	$ 21,874	$ 3,126
Valuation Adjustments							
Health Care Insurance Premium Revenue Recoveries	-	-	-	-	-	(14,851)	14,851
Other Write-Offs	2,000	-	2,000	-	2,000	3,977	(1,977)
Provision for Vacation Pay	-	-	-	-	-	124	(124)
Total Statutory Expenses and Valuation Adjustments	$ 27,000	$ -	$ 27,000	$ -	$ 27,000	$ 11,124	$ 15,876

[a] Adjustments include encumbrances and credit or recovery shortfalls. The increase is as a result of transfers of $3,343 for emerging capital purposes from the Department of Infrastructure pursuant to section 5 and 5(1)(a) of the Appropriation Act, 2009.

[b] Supplementary estimates were approved on March 1, 2010. Treasury Board approval is pursuant to section 24(2) of the *Financial Administration Act*.

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULES OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31
(in dollars)

	2010				2009
	Base Salary [1]	Other Cash Benefits [2]	Other Non-cash Benefits [3]	Total	Total
Deputy Minister [4][5]	$ 263,799	$ 379,378	$ 73,762	$ 716,939	$ 488,237
Executives - Assistant Deputy Ministers					
Information Strategic Services [6]	69,770	-	16,013	85,783	190,442
Health System Performance & Information Management [7]	91,811	-	22,732	114,543	-
Program Services [8]	-	-	-	-	220,599
Community and Population Health	170,529	-	41,564	212,093	220,499
Health Workforce	185,117	-	45,387	230,504	251,911
Health Policy and Service Standards	185,117	-	44,770	229,887	245,715
Health System Development [9]	109,314	31,808	30,544	171,666	174,460
Corporate Operations [10]	69,884	-	744	70,628	242,762
Financial Accountability [10][11]	80,087	-	21,854	101,941	-
Corporate Support [10][12]	123,293	-	30,648	153,941	-
Executives - Other					
Executive Director, Human Resources	151,545	-	37,699	189,244	203,591

Prepared in accordance with Treasury Board Directive 12/98 as amended

[1] Base salary includes pensionable base pay.

[2] Other cash benefits include vacation payments, overtime and lump sum payments.

[3] Other non-cash benefits include government's share of all employee benefits and contributions or payments made on behalf of employees including pension and supplementary retirement plan, health care, dental coverage, group life insurance, short and long-term disability plans, professional memberships and tution fees.

[4] Automobile provided, no dollar amount is included in other non-cash benefits.

[5] This position was occupied by two individuals during the year. The previous incumbent was Deputy Minister until January 15, 2010.

[6] This division was abolished effective July 1, 2009 as a result of restructuring.

[7] This division was established effective July 1, 2009 as a result of restructuring. The current incumbent is in an acting capacity.

[8] The previous incumbent was the ADM until April 7, 2009. This division was abolished on restructuring and responsibilites assigned to other divisions.

[9] The division was abolished effective July 1, 2009. The incumbent continued as the ADM until November 30, 2009 to help with the reorganization transition.

[10] This division was split into Financial Accountability and Corporate Support on restructuring effective July 1, 2009. The previous incumbent was in an acting capacity until June 30, 2009. This incumbent was on secondment to the Department of Health and Wellness and cost of salary and benefits were provided by the Department of Justice and Attorney General.

[11] The current incumbent became the ADM of Financial Accountability effective November 16, 2009. The previous incumbent was ADM of Corporate Support but continued to be responsible for this division until November 15, 2009

[12] The incumbent was in an acting capacity during July, 2009 and became ADM effective August 1, 2009. The incumbent was on secondment from the Department of Justice and Attorney General until July 31, 2009.

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULES OF RELATED PARTY TRANSACTIONS
FOR THE YEAR ENDED MARCH 31
(in thousands)

Related parties are those entities consolidated or accounted for on a modified equity basis in the Province of Alberta's financial statements. Related parties also include management in the department. Entities in the Ministry include Alberta Health Services and its controlled entities and the Health Quality Council of Alberta

The Department and its employees paid or collected certain taxes and fees set by regulation for permits, licences and other charges. These amounts were incurred in the normal course of business, reflect charges applicable to all users, and have been excluded from this schedule.

The Department had the following transactions with related parties recorded on the Statements of Operations and Financial Position at the amounts of consideration agreed upon between the related parties.

	Entities in the Ministry		Other Entities	
	2010	2009	2010	2009
Revenues				
Grants	$ -	$ -	$ 413,908	$ 279,752
Other	-	902	-	883
	$ -	$ 902	$ 413,908	$ 280,635
Expenses - Directly Incurred				
Grants	$ 8,819,174	$ 8,937,901	$ 75,679	$ 58,418
Other Services	-	685	8,024	6,894
	$ 8,819,174	$ 8,938,586	$ 83,703	$ 65,312
Receivable from	$ 1,780	$ 3,501	$ -	$ 11
Payable to	$ 82,689	$ 44,422	$ 3,738	$ 562

The Department also had the following transactions with related parties for which no consideration was exchanged. The amounts for these related party transactions are estimated based on the costs incurred by the service provider to provide the service. These amounts are not recorded in the financial statements but are disclosed in Schedule 8.

	Entities in the Ministry		Other Entities	
	2010	2009	2010	2009
Expenses - Incurred by Others				
Accommodation	$ -	$ -	$ 9,900	$ 9,103
Legal	-	-	2,555	2,954
Other	-	-	7,194	6,981
	$ -	$ -	$ 19,649	$ 19,038

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULES OF ALLOCATED COSTS
FOR THE YEAR ENDED MARCH 31
(in thousands)

	2010									2009
	Expenses - Incurred by Others				Statutory	Valuation Adjustments				(Restated - Note 3)
	Expenses [1]	Accomm-odation Costs [2]	Legal Services [3]	Other	Cancer Research & Prevention Investment	Health Care Insurance Premium Revenue Recoveries	Other Write-Offs	Vacation Pay	Total	Total
Ministry Support Services	$ 146,263	$ 9,900	$ 2,555	$ 7,194	$ -	$ -	$ -	$ 124	$ 166,036	$ 190,887
Physician Services	2,891,122	-	-	-	-	-	-	-	2,891,122	2,600,795
Provincial Programs	1,489,086	-	-	-	-	-	-	-	1,489,086	1,527,333
Healthy Living and Wellness	61,361	-	-	-	-	-	-	-	61,361	87,679
Health Authority Services	8,055,854	-	-	-	-	-	-	-	8,055,854	7,530,769
Infrastructure Support	210,534	-	-	-	-	-	-	-	210,534	857,907
H1N1 Pandemic Response	80,156								80,156	-
Cancer Research and Prevention Investment	-	-	-	-	21,874	-	-	-	21,874	19,257
Health Care Insurance Premium Revenue (Recoveries)/Write-Offs [4]	-	-	-	-	-	(14,851)	-	-	(14,851)	82,258
Other Write-Offs	-	-	-	-	-	-	3,977	-	3,977	272
	$12,934,376	$ 9,900	$ 2,555	$ 7,194	$ 21,874	$ (14,851)	$ 3,977	$ 124	$12,965,149	$12,897,157

[1] Expenses - Directly Incurred as per Statements of Operations, excluding valuation adjustments.

[2] Costs shown for Accommodation (includes grants in lieu of taxes) on Schedule 7.

[3] Costs shown for Legal Services on Schedule 7.

[4] Health Care Insurance Premium Revenue (Recoveries)/Write-Offs relate to Premiums and Fees revenue.

Unaudited Information

Ministry of Health and Wellness

Unaudited Information

MINISTRY OF HEALTH AND WELLNESS

STATEMENT OF REMISSIONS, COMPROMISES AND WRITE-OFFS

FOR THE YEAR ENDED MARCH 31, 2010

(UNAUDITED)
(in thousands)

	2010	2009
Compromises:		
Health Care Insurance Premiums	$ 122	$ 392
Write-offs:		
Health Care Insurance Premiums	39,175	231,030
Medical Claim Recoveries	2,240	2,232
Penalties, Interest and Miscellaneous Charges	481	1,521
Total Remissions, Compromises and Write-offs	$ 42,018	$ 235,175

The above statement has been prepared pursuant to Section 23 of the *Financial Administration Act*. The statement includes all remissions, compromises and write-offs made or approved during the fiscal year.

Health Authority Financial Statement Highlights

This section highlights the financial results of Alberta Health Services (AHS) and the Health Quality Council of Alberta (HQCA) for the fiscal year ended March 31, 2010.

The financial statements were prepared in accordance with Canadian Generally Accepted Accounting Principles (GAAP) and Alberta Health and Wellness' Financial Directives.

ALBERTA HEALTH SERVICES

Operating Results

- For fiscal 2009/2010 AHS reported an operating deficit of $238 million. This compares to a prior year deficit of $153 million.
- 2009/2010 expenditures were $10.5 billion, compared to $9.7 billion in the prior year — a 8.2 per cent increase overall, of which 4.7 per cent related to salaries and benefits. AHS employed 64,533 Full Time Equivalents during the year.
- Administration costs in 2009/2010 were $390 million, or 3.7 per cent of total expenditures of $10.5 billion. This compares to total administration costs in 2008/2009 of $324 million, or 3.3 per cent of total expenditures of $9.7 billion.

Financial Position

- AHS reported net assets and endowments of $128 million at March 31, 2010, a decrease of $193 million from the prior year.
- At March 31, 2010, AHS reported long-term debt of $276 million, an increase of $75 million from $201 million at March 31, 2009. AHS is compliant with its authorized borrowing limits.
- AHS reported capital assets of $6.2 billion at March 31, 2010, up from $5.5 billion in the prior year.

HEALTH QUALITY COUNCIL OF ALBERTA

Operating Results

- For fiscal 2009/2010 HQCA reported an operating surplus of $130 thousand. This compares to a prior year deficit of $27 thousand.
- 2009/2010 expenditures were $4.1 million, compared to $4.5 million in the prior year — an 8.7 per cent decrease overall, including a 7.6 per cent increase related to salaries and benefits. HQCA employed 17 Full Time Equivalents during the year.

Financial Position

- HQCA reported net assets of $646 thousand at March 31, 2010, an increase of $130 thousand from the prior year.
- HQCA has no long-term debt.
- HQCA reported capital assets of $33 thousand at March 31, 2010, down from $76 thousand in the prior year.

TABLE I

HEALTH AUTHORITY
SUMMARY OF OTHER FINANCIAL INFORMATION
FOR THE YEAR ENDED MARCH 31, 2010
(In Thousands)

	ALBERTA HEALTH SERVICES	HEALTH QUALITY COUNCIL OF ALBERTA	HEALTH AUTHORITY TOTAL	
	2009/2010 ACTUAL	2009/2010 ACTUAL	2009/2010 ACTUAL	2008/2009 ACTUAL
I. OPERATING SURPLUS/(DEFICIT) AS A % OF TOTAL REVENUE	-2.3%	3.1%	-2.3%	-1.6%
II. ADMINISTRATION COST AS A % OF TOTAL EXPENSES	3.7%	94.9%	3.8%	3.4%
III. WORKING CAPITAL				
Current Assets	1,386,498	1,755	1,388,253	1,478,584
Current Liabilities	1,901,214	1,142	1,902,356	1,877,374
WORKING CAPITAL RATIO	0.73	1.54	0.73	0.79
IV. ALBERTA HEALTH AND WELLNESS FUNDING COVERAGE *excludes unusual items*	84.8%	99.0%	84.8%	84.5%
V. AVERAGE REMAINING USEFUL LIFE OF CAPITAL EQUIPMENT IN YEARS *(includes information systems)*	3.2	0.5	3.2	3.4
VI. CAPITAL INVESTMENTS DURING THE YEAR				
Funded from Internal Resources				
Equipment	36,097	25	36,122	139,591
Facilities and Improvements	7,103	-	7,103	70,278
	43,200	25	43,225	209,869
Funded by External Parties				
Equipment	181,573	-	181,573	190,616
Facilities and Improvements	708,985	-	708,985	721,483
	890,558	-	890,558	912,099
Total capital investments during the year *excludes debt-funded and donated assets*	933,758	25	933,783	1,121,968
VII. TOTAL FTEs *(excludes Board)*	64,533	17	64,550	63,212

Financial Information

Alberta Health Services

Financial Statements

March 31, 2010

Alberta Health Services

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2010

Alberta Health Services

Management's Responsibility for Financial Reporting

Auditor's Report

Consolidated Statement of Operations

Consolidated Statement of Financial Position

Consolidated Statement of Changes in Net Assets

Consolidated Statement of Cash Flows

Notes to the Consolidated Financial Statements

Schedule 1 – Consolidated Schedule of Expenses by Object

Schedule 2 – Consolidated Schedule of Salaries and Benefits

Schedule 3 – Consolidated Schedule of Budget

Schedule 4 – Consolidated Schedule of Comparatives

Schedule 5 – Unaudited Consolidated Schedule of Facilities and Sites

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

MARCH 31, 2010

The accompanying consolidated financial statements for the years ended March 31, 2010 and 2009 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Generally Accepted Accounting Principles and the financial directives issued by Alberta Health and Wellness, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising written policies, standards and procedures, a formal authorization structure, and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained, and assets are adequately safeguarded.

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit and Finance Committee. This Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Board for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Audit and Finance Committee.

The Auditor General of Alberta provides an independent audit of the consolidated financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the consolidated financial statements prepared by management.

[Original signed by]

Dr. Stephen Duckett
President and Chief Executive Officer
Alberta Health Services

[Original signed by]

Chris Mazurkewich
Executive Vice President and Chief Financial Officer
Alberta Health Services

June 10, 2010

AUDITOR GENERAL *Alberta*

Auditor's Report

To the Members of the Alberta Health Services Board
and the Minister of Health and Wellness

I have audited the consolidated statements of financial position of Alberta Health Services as at March 31, 2010 and 2009 and the consolidated statements of operations, changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of Alberta Health Services' management. My responsibility is to express an opinion on these financial statements based on my audits.

I conducted my audits in accordance with Canadian generally accepted auditing standards. Those standards require that I plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In my opinion, these consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2010 and 2009 and the results of its operations and its cash flows for the years then ended in accordance with Canadian generally accepted accounting principles.

[Original signed by Merwan N. Saher]

CA
Auditor General

Edmonton, Alberta
June 10, 2010

CONSOLIDATED STATEMENT OF OPERATIONS
FOR THE YEAR ENDED MARCH 31, 2010

	2010		2009
	Budget (Note 3)	Actual	Actual (Note 4 (b))
Revenue:			
Alberta Health and Wellness contributions	$ 8,430,022	$ 8,883,012	$ 8,227,662
Other government contributions	80,980	81,422	66,646
Fees and charges	584,991	577,644	542,616
Ancillary operations	108,581	123,059	117,652
Donations	15,668	17,775	25,373
Investment and other income (Note 5)	246,984	250,907	282,682
Amortized external capital contributions	300,635	305,054	322,930
TOTAL REVENUE	9,767,861	10,238,873	9,585,561
Expenses:			
Inpatient acute nursing services	2,733,440	2,523,753	2,398,751
Emergency and outpatient services	1,146,381	1,151,994	1,099,206
Facility-based continuing care services	787,862	778,485	756,230
Ambulance services	315,918	326,319	43,970
Community-based care	730,069	684,790	545,980
Home care	367,807	383,224	393,159
Diagnostic and therapeutic services	1,723,008	1,810,102	1,717,480
Promotion, prevention and protection services	340,389	316,867	296,994
Research and education	203,659	215,872	227,366
Administration	439,696	390,154	324,356
Information technology	251,160	299,059	280,950
Support services	1,431,988	1,432,600	1,441,658
Amortization of facilities and improvements	167,584	147,338	161,391
Capital assets write down (Note 9 (c))	-	2,682	13,810
Funded transition costs (Note 6)	13,900	13,804	40,561
TOTAL EXPENSES (Schedule 1)	10,652,861	10,477,043	9,741,862
Deficiency of revenue over expenses before transfer	(885,000)	(238,170)	(156,301)
Transfer of HBA Services (Note 4 (a))	-	-	3,116
Deficiency of revenue over expenses	$ (885,000)	$ (238,170)	$ (153,185)

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31, 2010

	2010 Actual	2009 Actual (Note 4 (b))
ASSETS		
Current:		
Cash and cash equivalents (Note 8)	$ 977,216	$ 1,144,223
Accounts receivable	166,807	159,221
Contributions receivable from Alberta Health and Wellness	79,233	36,183
Inventories	108,339	91,109
Prepaid expenses	54,903	46,044
	1,386,498	1,476,780
Non-current cash and investments (Note 8)	999,614	1,807,319
Capital contributions receivable from Alberta Health and Wellness	109,947	16,500
Capital assets (Note 9)	6,151,112	5,539,407
Other assets (Note 10)	127,613	144,786
TOTAL ASSETS	$ 8,774,784	$ 8,984,792
LIABILITIES AND NET ASSETS		
Current:		
Accounts payable and accrued liabilities	$ 963,139	$ 902,723
Accrued vacation pay	357,410	330,599
Deferred contributions (Note 11)	567,727	630,620
Current portion of long-term debt (Note 13)	12,938	12,068
	1,901,214	1,876,010
Deferred contributions (Note 11)	163,250	181,346
Deferred capital contributions (Note 12)	1,046,140	1,696,776
Long-term debt (Note 13)	262,766	189,216
Unamortized external capital contributions	5,254,711	4,675,230
Other liabilities (Note 14)	18,431	45,424
	8,646,512	8,664,002
Net assets:		
Accumulated deficit (Note 16)	(527,235)	(343,219)
Accumulated net unrealized gains (losses) on investments	17,243	(17,737)
Internally restricted net assets invested in capital assets	628,114	671,596
Operating net assets	118,122	310,640
Endowments (Note 17)	10,150	10,150
	128,272	320,790
TOTAL LIABILITIES AND NET ASSETS	$ 8,774,784	$ 8,984,792

Commitments and contingencies (Note 18)

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET ASSETS
FOR THE YEAR ENDED MARCH 31, 2010

	2010						2009
	Accumulated deficit (Note 16)	Accumulated net unrealized gains/(losses) on investments	Internally restricted net assets invested in capital assets	Sub-total operating net assets	Endowments (Note 17)	Total	Total (Note 4 (b))
Balance at beginning of year	$ (343,219)	$ (17,737)	$ 671,596	$ 310,640	$ 10,150	$ 320,790	$ 514,735
Deficiency of revenue over expenses	(238,170)	-	-	(238,170)	-	(238,170)	(153,185)
Capital assets purchased with internal funds	(43,200)	-	43,200	-	-	-	-
Amortization of internally funded capital assets	106,740	-	(106,740)	-	-	-	-
Repayment of long-term debt used to fund capital assets	(10,495)	-	10,495	-	-	-	-
Transfer of land from unamortized external capital contributions	-	-	5,723	5,723	-	5,723	-
Purchase of land	-	-	-	-	-	-	3,327
Net unrealized gains (losses) arising during the period on investments	-	39,382	-	39,382	-	39,382	(45,727)
Transfer of net realized losses (gains) on investments to revenue	-	(4,402)	-	(4,402)	-	(4,402)	3,707
Net repayment of life lease deposits	(604)	-	604	-	-	-	-
Reclassification adjustments	1,713	-	3,236	4,949	-	4,949	(2,067)
Balance at end of year	$ (527,235)	$ 17,243	$ 628,114	$ 118,122	$ 10,150	$ 128,272	$ 320,790

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31, 2010

	2010		2009
	Budget (Note 3)	Actual	Actual (Note 4 (b))
Operating activities:			
Deficiency of revenue over expenses	$ (885,000)	$ (238,170)	$ (153,185)
Non-cash transactions:			
Amortization expense, loss on disposal and write down (Schedule 1)	466,000	411,585	427,651
Amortized external capital contributions	(300,000)	(305,357)	(322,930)
Other	9,000	(41,979)	37,367
Changes in non-cash working capital	(367,000)	1,520	534,023
Cash generated from (used by) operating activities	(1,077,000)	(172,401)	522,926
Investing activities:			
Purchase of capital assets:			
Internally funded equipment	(150,000)	(36,097)	(139,449)
Internally funded facilities and improvements	(50,000)	(7,103)	(70,278)
Externally funded equipment	(144,000)	(181,573)	(190,616)
Externally funded facilities and improvements	(1,177,000)	(708,985)	(721,483)
Debt funded facilities and improvements	(96,000)	(89,107)	(56,742)
Purchase of investments	-	(341,196)	(374,668)
Proceeds on sale of investments	134,000	412,688	347,079
Allocations from (to) non-current cash	884,000	775,595	(419,192)
Changes in non-cash working capital	(31,000)	(53,911)	54,322
Other	8,000	(329)	(2,951)
Cash generated from (used by) investing activities	(622,000)	(230,018)	(1,573,978)
Financing activities:			
Capital contributions received	294,000	160,992	1,452,584
Proceeds from long-term debt	190,000	88,830	55,417
Principal payments on long-term debt	(10,000)	(14,410)	(10,119)
Other	-	-	(2,386)
Cash generated from (used by) financing activities	474,000	235,412	1,495,496
Net increase (decrease) in current cash and cash equivalents	(1,225,000)	(167,007)	444,444
Current cash and cash equivalents, beginning of year	1,049,000	1,144,223	699,779
Current cash and cash equivalents, end of year	$ (176,000)	$ 977,216	$ 1,144,223

The accompanying notes and schedules are part of these consolidated financial statements.

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2010

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established April 1, 2009 under the *Regional Health Authorities Act* (Alberta). Effective April 1, 2009, Aspen Regional Health Authority, Calgary Health Region, Capital Health, Chinook Regional Health Authority, David Thompson Regional Health Authority, Northern Lights Health Region, Palliser Health Region, and Peace Country Health were disestablished along with the Alberta Cancer Board, Alberta Mental Health Board, and Alberta Alcohol and Drug Abuse Commission. All the assets, liabilities, rights and obligations of the disestablished entities were assumed by East Central Health, whose name changed to Alberta Health Services.

Effective April 1, 2009 the operations and administration of emergency medical services (EMS) within the Province of Alberta (Province) were transitioned from Alberta Health and Wellness (AHW) to AHS.

AHS's mission is to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans. AHS's operations include the facilities and sites listed in Schedule 5. AHS is a registered charity under the Income Tax Act and is exempt from the payment of income tax.

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

The financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and the reporting requirements of AHW's Financial Directive 1.

These financial statements have been prepared on a consolidated basis. Included in these consolidated financial statements are the following wholly owned subsidiaries:

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(i) Calgary Laboratory Services Ltd. (CLS), who provides medical diagnostic services in Calgary and Southern Alberta.
(ii) Capital Care Group Inc. (CCGI), who manages continuing care programs and facilities in the Edmonton area.
(iii) Carewest, who manages continuing care programs and facilities in the Calgary area.
(iv) 1115399 Alberta Inc. (operating as Chemical Exposure Support Services), Capital Health Tele-Ophthalmology Inc., and Edmonton Heart Systems Inc. were amalgamated into AHS effective December 31, 2009.

The transactions between AHS and these subsidiaries have been eliminated on consolidation. All consolidated entities of AHS are exempt from the payment of income tax.

AHS uses the proportionate consolidation method to account for its 50% interest in the Northern Alberta Clinical Trials Centre joint venture with the University of Alberta, and its 50% interest in the Primary Care Networks disclosed in Note 19 (b).

These consolidated financial statements do not include the assets, liabilities and operations of controlled foundations (Note 19 (c)), or voluntary or private facilities providing health services in the Province (Note 19 (d)). These consolidated financial statements do not include trust funds administered on behalf of others (Note 20).

(b) Revenue Recognition

These consolidated financial statements have been prepared using the deferral method of accounting for contributions; the key elements of our revenue recognition policies are:

(i) Unrestricted contributions are recognized as revenue in the year receivable.

(ii) Externally restricted non-capital contributions are deferred and recognized as revenue in the year the related expenses are incurred.

(iii) Externally restricted capital contributions are recorded as deferred capital contributions until invested in capital assets. Amounts expended, representing externally funded capital assets, are then transferred to unamortized external capital contributions. Unamortized external capital contributions are recognized as revenue in the year the related amortization expense of the funded capital asset is recorded.

(iv) Contributions receivable from Alberta Health and Wellness and capital contributions receivable from Alberta Health and Wellness are recorded as receivable when confirmed with AHW.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(v) Endowments and externally restricted contributions to purchase capital assets that will not be amortized are treated as direct increases to net assets.

(vi) Investment income includes dividend and interest income, and realized gains or losses on the sale of investments. Unrealized gains and losses on available for sale investments are included directly in net assets or deferred contributions as appropriate, until the related investments are sold. Restricted investment income is recognized as revenue in the year in which the related expenses are incurred. Other unrestricted investment income is recognized as revenue when earned.

(vii) Donations and contributions in kind are recorded at fair value when such value can reasonably be determined.

(viii) Revenue from sales of goods and services is recorded in the period that goods are delivered or services are provided.

(c) Full Cost

AHS accounts for all costs of services for which it is responsible. Full cost transactions comprise the following:

(i) Revenue earned by contracted health service providers from AHW designated fees and charges are recorded as AHS's fees and charges. An equivalent amount is recorded as program expenses as this revenue funds part of the cost of AHS's programs.

(ii) AHW payments directly to contracted health service providers are recorded as revenue and an equivalent amount is recorded as program expenses as these payments represent part of the cost of AHS's programs.

(iii) The estimated cost for use of acute care facilities not owned by AHS is recorded as revenue from other government contributions and as program expenses, since AHS's contract payments do not include an amount for the use of these facilities.

(iv) The estimated cost for use of non-acute care facilities not owned by AHS and provided to AHS at zero or nominal rent is recorded as other government contributions and as program expenses.

(v) Other assets, supplies and service contributions that would otherwise have been purchased are recorded as revenue and expenses, at fair value at the date of contribution, when a fair value can be reasonably determined. Volunteers contribute a significant amount of time each year to assist AHS in carrying out its programs and services. However, contributed services of volunteers are not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(d) Inventories

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and current replacement value. All other inventories are valued at lower of cost (defined as moving average cost) and net realizable value.

(e) Investments

Investments are accounted for in accordance with the accounting policies described in Note 2(f). Transaction costs associated with the acquisition and disposal of investments are capitalized and are included in the acquisition costs or reduce proceeds on disposal. Investment management fees are expensed as incurred. The purchase and sale of investments are accounted for using trade-date accounting.

(f) Financial Instruments

AHS has classified its financial assets and financial liabilities as follows:

Financial Assets and Liabilities	Classification	Subsequent Measurement and Recognition
Cash and cash equivalents	Held for trading	Measured at fair value with changes in those fair values recognized in the Consolidated Statement of Operations.
Investments	Available for sale	Measured at fair value with changes in fair values recognized in the Consolidated Statement of Changes in Net Assets or deferred contributions until realized, at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
Accounts receivable	Loans and receivables	After initial fair value measurement, measured at amortized cost using the effective interest rate method.
Accounts payable, long-term debt, and life lease deposits	Other financial liabilities	After initial fair value measurement, measured at amortized cost using the effective interest rate method.

AHS does not use hedge accounting and is not impacted by the requirements of Canadian Institute of Chartered Accountants (CICA) accounting standard Section 3865 – Hedges. AHS as a not-for-profit organization has elected to not apply the standards for embedded derivatives in non-financial contracts.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

When it is determined that an impairment of a financial instrument classified as available for sale is other than temporary, the cumulative loss that had been recognized directly in net assets or deferred contributions is removed and recognized in the Consolidated Statement of Operations even though the financial asset has not been derecognized. Impairment losses recognized in the Consolidated Statement of Operations for a financial instrument classified as available for sale are not reversed.

The carrying value of current cash and cash equivalents, accounts receivable, accounts payable, and short-term borrowings approximate their fair value because of the short term nature of these items. Unless otherwise noted, it is management's opinion that AHS is not exposed to significant interest, currency or credit risks arising from its financial instruments.

Further disclosure on financial instruments is provided in Note 2(e) Investments, Note 8 Cash, Cash Equivalents and Investments, and Note 13 Long-term Debt.

(g) Capital Assets

Capital assets and work in progress are recorded at cost. Capital assets acquired from other government organizations are recorded at the carrying value of that government organization. Capital assets with unit costs less than five thousand dollars are expensed. Information systems with unit costs less than two hundred and fifty thousand dollars are expensed.

Capital assets are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-40 years
Equipment	2-20 years
Information systems	3-5 years
Leased facilities and improvements	term of lease
Building service equipment	5-30 years
Land improvements	5-25 years

Work in progress, which includes facilities and improvements projects and development of information systems, is not amortized until after a project is complete. Leases transferring substantially all benefits and risks of capital asset ownership are reported as capital asset acquisitions financed by long-term obligations.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(h) Asset Retirement Obligations

AHS recognizes the fair value of a future asset retirement obligation as a liability in the period in which it incurs a legal obligation associated with the retirement of tangible long-lived assets that results from the acquisition, construction, development, and/or normal use of the assets. AHS concurrently recognizes a corresponding increase in the carrying amount of the related long-lived asset that is amortized over the life of the asset. The fair value of the asset retirement obligation is estimated using the expected cash flow approach that reflects a range of possible outcomes discounted at a credit-adjusted risk-free interest rate.

Subsequent to the initial measurement, the asset retirement obligation is adjusted at the end of each period to reflect the passage of time and changes in the estimated future cash flows underlying the obligation. Changes in the obligation due to the passage of time are recognized as an operating expense using the effective interest method. Changes in the obligation due to changes in estimated cash flows are recognized as an adjustment of the carrying amount of the related long-lived asset that is amortized over the remaining life of the asset.

An asset retirement obligation related to the removal of hazardous material that would be required as part of a capital project is only recognized when there is approval from the Minister of Health and Wellness to proceed with the project.

(i) Employee Future Benefits

AHS participates in the following registered benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employee Pension Plan (MEPP). These multi-employer public sector final average plans provide pensions for participants, based on years of service and earnings. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). As these plans are multi-employer plans and sufficient information is not available, these plans are accounted for on a defined contribution basis.

AHS administrates a defined contribution pension plan (DC plan) for certain employee groups. AHS also sponsors Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups. Under the DC plan and GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. These plans provide participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS sponsors three defined benefit Supplemental Pension Plans (SPPs) which are funded. These plans cover certain employees and supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). A majority of the SPPs are final average plans, however, certain participant groups have their benefits determined on a career average basis. Also, some participant groups receive post-retirement indexing similar to the benefits provided under the registered defined benefit pension plans; while others receive non-indexed benefits. The obligations and costs of these benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service and management's best estimate assumptions, including a market-related discount rate. Due to *Income Tax Act* (Canada) requirements, the SPPs are subject to the Retirement Compensation Arrangement (RCA) rules, therefore approximately half the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SPPs are invested in a fixed income portfolio.

The net benefit cost of SPP's reported in these financial statements include the current service cost, interest cost on the current service cost and obligations, as well as the amortization of past service cost, initial obligations and net actuarial gains and losses. These amounts are offset by the expected return on the plans' assets.

Past service costs, including the initial obligations of the plans, are amortized on a straight-line basis over the average remaining service lifetime of the relevant employee group. Cumulative net actuarial gains or losses over 10 percent of the greater of the benefit obligation and fair value of the plans' assets, are amortized on a straight-line basis over the average remaining service lifetime of the employee group. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net benefit cost in the following year.

Employees who participate in the MEPP and whose benefits are limited by the *Income Tax Act* (Canada) are eligible to participate in the Supplementary Retirement Plan for Public Service Managers (SRP) for post July 1, 1999 service. AHS ceased contributions to the SRP on April 1, 2009.

AHS provides its employees with basic life, accidental death and dismemberment, short term disability, long term disability, extended health, dental and vision benefits through benefits carriers. AHS's contributions are expensed to the extent that they do not relate to discretionary reserves. AHS fully accrues its obligations for employee non-pension future benefits.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(j) Internally Restricted Net Assets Invested in Capital Assets

AHS discloses internally restricted net assets invested in capital assets separately on the Consolidated Statement of Financial Position and Consolidated Statement of Changes in Net Assets. The AHS Board has approved the restriction of net assets equal to the net book value of internally funded capital assets that will be amortized.

(k) Grants for Research and Other Initiatives

AHS awards grants to other organizations for research and other initiatives. The term of the grants range from less than one year to more than one year. AHS records the committed value of the grant awarded as an expense when it has been approved and when the agreement between AHS and the principal investigator has been executed.

(l) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. The amounts recorded for amortization of capital assets and amortization of external capital contributions are based on the estimated useful life of the related assets. The amounts recorded for asset retirement and employee future benefits obligations are based on estimated future cash flows. Actual results could differ materially from these estimates.

(m) Capital Disclosure

For operating purposes, AHS defines capital as including working capital and unrestricted net assets. For capital purposes, AHS defines capital as including deferred capital contributions, long term debt, unamortized external capital contributions, and internally restricted net assets invested in capital assets.

AHS's objectives for managing capital are:

- In the short term, to safeguard its financial ability to continue to deliver health services; and
- In the long term, to plan and build sufficient physical capacity to meet future needs for health services.

The majority of AHS's operating funds are from AHW which is paid on the first of each month. As a result, significantly less working capital is required. AHS monitors and forecasts its working capital and cash flow.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHW approves health care facilities based on long-term capital plans and provides the majority of the funding through one-time capital grants. AHS funds the required equipment and systems by a combination of allocating a portion of operating funds and obtaining external funding from charitable donations and capital grants. AHS borrows to finance capital investments related to ancillary operations since AHW does not fund ancillary operations.

AHS complied with all debt covenants during the year. In the event of default, the entire outstanding indebtedness secured by and payable to Alberta Capital Financing Authority (ACFA), at their option, becomes due and payable forthwith and without notice to AHS. ACFA may also elect to retain all or any part of the collateral in satisfaction of the indebtedness of AHS. AHS monitors and forecasts all debt covenants.

Where AHS has incurred an accumulated deficit, legislation requires submission of a deficit elimination plan (Note 16).

(n) Accounting Policy Changes

As of April 1, 2009 AHS has adopted the new CICA accounting standard Section 4470 - Disclosure of Allocated Expenses. The standard requires AHS to disclose policies adopted for the allocation of fundraising and general support expenses among functions, the nature of the expenses being allocated, the basis on which such allocations have been made, and the functions to which they have been allocated.

AHS does not allocate any fundraising costs. AHS allocates general support and other expenses to comply with the Canadian Institute of Health Information standards. The majority of these allocations are from groupings for accountability purposes to where they contribute directly to the output of one function.

In December 2006, the CICA issued Section 3862 Financial Instruments Disclosures and Section 3863 Financial Instruments Presentation which replaces Section 3861 Financial Instruments Disclosure and Presentation. As a not-for-profit organization, AHS has elected to not adopt the new standards and has continued to disclose for financial instruments under Section 3861.

Note 3 Budget

A preliminary business plan with a budgeted deficit of $885,000 was approved by the Board on June 30, 2009 and the full financial plan was submitted to the Minister of Health and Wellness on August 10, 2009. Reclassifications between revenue and expense categories were approved by the Board on December 3, 2009 and submitted to the Minister of Health and Wellness on December 10, 2009. The reported budget reflects the original $885,000 deficit and additional reclassifications required for more consistent presentation with current and prior year results (Schedule 3).

Over the course of the fiscal year, the Minister provided additional funding of $343,000 for accumulated deficit elimination and $58,700 for H1N1 response costs. The Board has allocated these additional resources to address the expectations of the funding, however the approved budget has not been changed.

Note 4 Restructure of the Health Services Delivery System in Alberta

(a) Provincial Health Authorities of Alberta operating as Health Boards of Alberta

The Provincial Health Authorities of Alberta operating as Health Boards of Alberta (HBA Services) was transferred to AHS (formerly East Central Health) on November 1, 2008. All assets and liabilities including all rights, obligations, commitments and contingencies were transferred to AHS at the carrying values. Net assets at the time of transfer were $3,116.

(b) Regional health authorities and boards

As described in Note 1, effective April 1, 2009, all business affairs, assets, liabilities, rights and obligations of the Province's former nine regional health authority boards, Alberta Mental Health Board, Alberta Cancer Board and Alberta Alcohol and Drug Abuse Commission were transferred to Alberta Health Services. The continuity of control over the business operations and net assets transferred to AHS did not change as the Government of Alberta continues to retain control over AHS. Since there was no substantive change in control, the carrying value of these items was retained by AHS upon transfer. Financial statements of AHS presented for prior periods reflect the financial position and results of operations as if AHS had always been assigned with the business affairs of the disestablished health authorities and health boards. Accordingly, balances and transactions between the disestablished health authorities were eliminated and amounts have been reclassified and adjusted to match current year presentation (Schedule 4).

Note 4 Restructure of Health Services Delivery System in Alberta (continued)

	As at March 31, 2009			For the Year Ended March 31, 2009	
	Assets	Liabilities	Net Assets	Revenue	Expenses
Eliminations	$ (68,993)	$ (68,993)	$ -	$ (169,266)	$ (169,266)
Reclassifications	(3,497)	(3,126)	(371)	8,597	8,597

(c) Ambulance services

Effective April 1, 2009, the administration and operations of emergency medical services (EMS) within the Province were transitioned to AHS. The transition was made through contracts with previous service providers, and in some cases the transfer of service operations to AHS. Also effective April 1, 2009, the contract for rotary air ambulance services by the Alberta Shock Trauma Air Rescue Society (STARS) was transitioned from AHW to AHS. Ambulance services in the Consolidated Statement of Operations includes $306,048 of expenses related to EMS and STARS. Subsequent to year end, fixed wing and other rotary air ambulance services will also be transitioned to AHS.

Note 5 Investment and Other Income

	2010	2009
Realized investment income	$ 25,480	$ 31,710
Other than temporary impairment of investments	-	(5,023)
Other income	225,427	255,995
	$ 250,907	$ 282,682

Note 6 Funded Transition Costs

AHS received $80,000 in funding from AHW for the costs of transitioning to AHS (Note 1). These costs consist of severance costs and termination benefits, professional services, consulting costs, transferring employees to LAPP, unfunded supplemental pension plan obligations and payments and other applicable transition expenses. Of the total funding, $54,365 was expensed in the Consolidated Statement of Operations (2010 - $13,804, 2009 - $40,561), $21,377 was used in 2009 to fund the supplemental pension plans, and $4,258 was capitalized in 2009 in the Consolidated Statement of Financial Position. The offsetting revenue of $13,804 (2009 - $66,196) is reported as Alberta Health and Wellness contributions.

Note 7 Funded H1N1 Costs

During the year, AHS responded to the need for providing public health awareness, vaccination and assessment clinics, and emergency and acute care for the outbreak of H1N1 influenza. AHW provided the vaccine at no cost to AHS and has funded the following costs incurred by AHS:

	2010
Inpatient acute nursing services	$ 15,295
Emergency and outpatient services	4,379
Facility-based continuing care services	511
Ambulance services	140
Diagnostic and therapeutic services	5,646
Promotion, prevention and protection services	22,619
Support services	363
Funded costs expensed in the Consolidated Statement of Operations	48,953
Inventory purchases in the Consolidated Statement of Financial Position	4,876
Capital asset purchases in the Consolidated Statement of Financial Position	4,871
Total funded H1N1 costs	$ 58,700

The offsetting revenue of $58,700 is reported as Alberta Health and Wellness contributions.

Note 8 Cash, Cash Equivalents and Investments

	2010		2009	
	Fair Market Value	Cost	Fair Market Value	Cost
Cash	$ 1,552,995	$ 1,552,995	$ 2,325,364	$ 2,325,364
Money market securities	65,101	65,095	257,182	257,186
Fixed income securities	251,528	247,374	264,945	265,813
Equities	107,206	94,123	104,051	120,916
	$ 1,976,830	$ 1,959,587	$ 2,951,542	$ 2,969,279
Classified as:				
Current				
Unrestricted	$ 313,663		$ 305,867	
Restricted	663,553		838,356	
	977,216		1,144,223	
Non-current				
Restricted	999,614		1,807,319	
Total cash, cash equivalents and investments	$ 1,976,830		$ 2,951,542	

Cash and cash equivalents consists of cash on hand, balances with banks, and investments in money market securities with original maturities of less than three months which will be used to fund AHS's activities over the next 12 months.

In order to earn optimal financial returns at an acceptable level of risk, AHS has established an investment bylaw with maximum asset mix ranges of 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities, and 0% to 40% for equities. Risk is reduced through asset class diversification, diversification within each asset class and quality constraints on fixed income securities and equity investments.

(a) Interest Rate Risk

AHS manages the interest rate risk exposure of its fixed income investments by management of average duration and laddered maturity dates.

Money market securities are comprised of Government of Canada treasury bills maturing between April 2010 and June 2010 and bear interest at an average effective yield of 0.22% per annum.

Note 8 Cash, Cash Equivalents and Investments (continued)

Fixed income securities, such as bonds, have an effective yield of 3.7% per year, maturing between 2010 and 2108. As at March 31, 2010, the securities have the following maturity structure:

1 – 5 years	42 %
6 – 10 years	30 %
Over 10 years	28 %

(b) Currency Rate Risk

AHS is exposed to foreign exchange fluctuations on its investments denominated in foreign currencies. However, this risk is limited by the fact that AHS's investment bylaw limits non-Canadian equities to 25% of total equities.

(c) Credit and Market Risks

AHS is exposed to credit risk from the potential non-payment of accounts receivable. However, the majority of the value of AHS's receivables are from AHW, therefore credit risk is considered to be minimal.

AHS's investment bylaw restricts the types and proportions of eligible investments, thus mitigating AHS's exposure to market risk. Money market securities are limited to a rating of R1 or equivalent or higher and no more than 10% may be invested in any one issuer. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total fixed income securities. Investments in debt and equity of any one issuer are limited to 5% of the issuer's total debt and equity. Short selling is not permitted.

Note 9 Capital Assets

	2010			2009
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Facilities and improvements	$ 5,087,667	$ 1,952,252	$ 3,135,415	$ 2,865,260
Work in progress	1,824,049	-	1,824,049	1,515,163
Equipment	1,561,898	1,019,678	542,220	563,110
Information systems	759,969	493,887	266,082	228,240
Leased facilities and improvements	156,652	66,076	90,576	95,832
Land	106,330	-	106,330	106,330
Building service equipment	341,765	173,077	168,688	143,729
Land improvements	63,479	45,727	17,752	21,743
	$ 9,901,809	$ 3,750,697	$ 6,151,112	$ 5,539,407

(a) Leased Land

Land at the following sites has been provided to AHS at nominal values:

Site	Leased from	Lease expiry
Alberta Children's Hospital	University of Calgary	2101
Banff Health Unit	Mineral Springs Hospital	2028
Cross Cancer Institute parkade	University of Alberta	2019
Foothills Medical Centre parkade	University of Calgary	2054
McConnell Place North	City of Edmonton	2035
Northeast Community Health Centre	City of Edmonton	2048

(b) Leased Equipment

Equipment includes assets acquired through capital leases at a cost of $11,283 (2009 - $11,302) with accumulated amortization of $10,415 (2009 - $11,057).

(c) Capital Asset Write-Down

During the year AHS discontinued operations of the Raymond Care Centre and Picture Butte Municipal Hospital, and recorded a write-down of $2,682 to reduce the facilities' carrying value to their fair market value. During the prior year, AHS discontinued development of a human resources information system and recorded a write-down of $13,810 to reduce the carrying value to $nil.

Note 9 Capital Assets (continued)

(d) Option to Purchase Hospital

AHS owns the land and buildings of the Grey Nuns Community Hospital and has contracted Covenant Health to operate it. Covenant Health has an option to purchase the land and buildings of the Grey Nuns Community Hospital at market value subject to consent from the Minister of Health and Wellness.

Note 10 Other Assets

	2010	2009
Long-term care partnerships – demand loans (Note 11 (a))	$ 93,904	$ 81,581
Contributions receivable	20,514	50,690
Other non-current assets	13,195	12,515
	$ 127,613	$ 144,786

Note 11 Deferred Contributions

Deferred contributions represent unspent externally restricted resources. Changes in the deferred contributions balance are as follows:

	2010			2009
	AHW	Others	Total	Total
Balance beginning of the year	$ 517,547	$ 294,419	$ 811,966	$ 679,706
Amount received during the year	737,151	155,035	892,186	1,100,331
Amount transferred from (to) deferred capital contributions	(6,280)	1,805	(4,475)	93,553
Interest earned	1,831	1,333	3,164	5,007
Amount recognized as revenue	(827,157)	(144,707)	(971,864)	(1,066,631)
Balance at end of the year	$ 423,092	$ 307,885	$ 730,977	$ 811,966

Note 11 Deferred Contributions (continued)

The balance at the end of the year is restricted for the following purposes:

	2010			2009
	AHW	Others	Total	Total
Current:				
Mental health and Safe Communities	$ 128,572	$ 1,329	$ 129,901	$ 127,427
Research and education	3,604	69,675	73,279	63,994
Cancer prevention and research	36,270	15,410	51,680	43,911
Infrastructure maintenance	45,930	618	46,548	74,266
Primary Care Networks	41,826	-	41,826	39,194
Physician revenue and Alternate Relationship Plans	37,380	1,804	39,184	41,836
Promotion, prevention and community	18,428	16,372	34,800	48,371
Continuing care and seniors health	22,698	3,480	26,178	26,874
EMS transition	18,318	-	18,318	33,312
Diagnostic and therapeutic services	12,515	3,102	15,617	11,103
Emergency and outpatient services	6,243	7,606	13,849	17,377
Healthy Workforce Action Plan	785	10,343	11,128	10,470
Information technology	10,476	610	11,086	9,987
Inpatient acute nursing services	5,326	4,763	10,089	17,738
Wait times	9,898	-	9,898	13,129
Pandemic	8,613	-	8,613	10,801
Regional Shared Health Information Program	8,090	-	8,090	10,273
Telehealth	7,383	39	7,422	9,009
Support services	637	3,535	4,172	3,656
Student health initiatives	-	547	547	498
AHS transition	-	-	-	13,804
Other	100	5,402	5,502	3,590
	423,092	144,635	567,727	630,620
Non-current:				
Long term care partnerships [a]	-	157,435	157,435	171,750
Other	-	5,815	5,815	9,596
	-	163,250	163,250	181,346
	$ 423,092	$ 307,885	$ 730,977	$ 811,966

Note 11 Deferred Contributions (continued)

(a) Long-term care partnership agreements

AHS has entered into partnership with private and voluntary health service providers to build and operate long-term care facilities within the Province. The Government of Alberta has supported these partnerships through providing one-time, upfront capital funding to enable AHS and the voluntary and private partners to develop the approved infrastructure. Two partnership models have been used for the payment of the grant from AHS to the partnership organizations; the Supplementary Payment Model and the Modified Mortgage Model.

Under the Supplementary Payment Model, AHS makes annual payments to the partner over the term of the partnership contract, which is usually the expected useful life of the infrastructure. Amounts invested under the terms of long-term care partnership agreements will be utilized to fund future payments to providers over the next 23 years. These payments have a net present value of $26,067 at March 31, 2010 (2009 - $28,457) discounted at 3.0% (2009 – 2.5%). The cash, cash equivalents and investments have a market value at March 31, 2010 of $37,020 (2009 - $32,223). AHS is subject to risk to meet the payment obligations as they become due.

AHS recognizes the supplementary payment expenses in facility-based continuing care services on the Consolidated Statement of Operations and recognizes an equal amount of revenue as other government contributions through the amortization of deferred contributions long-term care partnership projects. Investment income earned, net of management fees, is recorded as an increase to both the investment base and the deferred contribution.

Under the Modified Mortgage Model, AHS provides a demand loan to the partner who uses the funds to construct the infrastructure. The loan is forgivable over the useful life of the infrastructure. The loan is repayable on demand, is secured by the facility and is forgivable for services rendered by the owner over the life of the facility. AHS does not accrue interest on the loan as AHS intends to forgive the balance of the loan following the expiry of the term of the agreement.

AHS amortizes the long-term care partnership project demand loans (Note 10) to facility-based continuing care services on the Consolidated Statement of Operations and recognizes an equal amount of revenue as other government contributions through the amortization of deferred contributions long-term care partnership projects.

Note 12 Deferred Capital Contributions

Deferred capital contributions represent unspent externally restricted resources related to capital assets. Changes in the deferred capital contributions balance are as follows:

	2010			2009
	AHW	Others	Total	Total
Balance beginning of the year	$ 1,607,113	$ 89,663	$ 1,696,776	$ 1,778,304
Amount received during the year	207,544	28,913	236,457	926,463
Amount transferred to unamortized external capital contributions	(827,552)	(63,596)	(891,148)	(915,094)
Amounts transferred from (to) deferred contributions	6,280	(1,805)	4,475	(93,553)
Interest earned	271	1	272	656
Other	358	(1,050)	(692)	-
Balance at end of the year	$ 994,014	$ 52,126	$ 1,046,140	$ 1,696,776

The balance at the end of the year is restricted for the following purposes:

	2010			2009
	AHW	Others	Total	Total
Facilities and improvements:				
Infrastructure maintenance projects	$ 158,031	$ -	$ 158,031	$ 96,275
Calgary South Health Campus	93,548	-	93,548	316,994
The Edmonton Clinic	102,731	-	102,731	199,472
Capital escalation	63,658	-	63,658	63,658
Rockyview General Hospital	35,909	-	35,909	62,861
Peter Lougheed Centre	22,045	-	22,045	55,080
Foothills Medical Centre	18,702	-	18,702	100,060
Royal Alexandra Hospital – New North Treatment Tower	26,653	7,055	33,708	52,049
Other less than $50,000	258,000	13,850	271,850	457,996
	779,277	20,905	800,182	1,404,445
Information systems	159,989	6,719	166,708	221,435
Equipment	54,748	24,502	79,250	70,896
	$ 994,014	$ 52,126	$ 1,046,140	$ 1,696,776

Note 13 Long-term Debt

	2010	2009
Debentures payable: [i]		
Parkade loan #1	$ 48,747	$ 50,722
Parkade loan #2	44,020	45,664
Parkade loan #3	53,332	55,000
Parkade loan #4	5,000	-
Calgary Laboratory Services purchase	22,697	28,535
Term loan [ii]	83,000	-
Mortgages payable	-	2,022
Obligation under capital lease [iii]	16,042	15,955
Other	2,866	3,386
	$ 275,704	$ 201,284
Current	$ 12,938	$ 12,068
Non-current	262,766	189,216
	$ 275,704	$ 201,284
Fair value of total long-term debt [iv]	$ 282,242	$ 209,945

(i) AHS issued debentures to Alberta Capital Financing Authority (ACFA), a related party, to finance the construction of parkades and the purchase of the remaining 50.01% ownership interest in CLS. AHS has pledged as security for these debentures revenues derived directly or indirectly from the operations of all parking facilities being built, renovated, owned and operated by AHS.

As at March 31, 2010, $5,000 of $181,000 has been advanced to AHS relating to the Parkade loan #4 debenture with the remaining to be drawn by September 1, 2011. Semi-annual principal and interest payments of $7,165 will commence March 1, 2012.

The maturity dates and interest rates for the debentures are as follows:

	Maturity Date	Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Calgary Laboratory Services purchase	May 2013	4.6810%

Note 13 Long-term Debt (continued)

(ii) AHS has obtained a term loan facility of $181,000 during 2010, of which $83,000 has been drawn at March 31, 2010. The facility has been secured by the issuance of the Parkade #4 debenture to ACFA. Although the loan is repayable on demand, repayment terms are for monthly payment of interest only at 2.755%, with the full principal repayment due upon maturity on September 1, 2011. Management does not believe that the demand features of the callable debt will be exercised in the current period.

(iii) The capital lease expires January 2028. The implicit interest rate payable on this lease is 6.5%.

(iv) The fair value of long-term debt is estimated based on market interest rates from ACFA for debentures of similar maturity.

(v) As at March 31, 2010 AHS held a $220,000 revolving demand facility with a Canadian chartered bank which may be used for operating purposes. Draws on the facility bear interest at the bank's prime rate less 0.5% per annum. As at March 31, 2010, AHS has no draws against this facility.

AHS also holds a $40,000 revolving demand letter of credit facility which may be used to secure AHS's obligations to third parties relating to construction projects. As at March 31, 2010, AHS had $4,305 in letters of credit outstanding against this facility.

AHS is committed to making payments as follows:

Year ended March 31	Debentures Payable, Term/Other Loan and Mortgages Payable Principal payments	Capital Lease Minimum lease payments
2011	$ 11,852	$ 1,716
2012	98,113	1,659
2013	15,277	1,465
2014	10,040	1,453
2015	6,870	1,453
Thereafter	117,510	19,752
	$ 259,662	27,498
Less: interest		11,456
		$ 16,042

During the year, the amount of interest expense was $8,845 (2009 - $7,091).

Note 14 Other Liabilities

Other liabilities are made up of the following balances:

	2010	2009
Asset retirement obligations [a]	$ 10,713	$ 13,029
Life lease deposits [b]	12,603	13,625
Supplemental pension plans accrued benefit (asset) liability [c]	(6,180)	14,491
Other	1,295	4,279
	$ 18,431	$ 45,424

(a) Asset Retirement Obligations

The asset retirement obligation (ARO) represents the legal obligation associated with the removal of asbestos during planned renovations of AHS buildings. The total undiscounted amount of the estimated cash flows required to settle the recorded obligation is $11,474 (2009 - $13,767), which has been discounted using a weighted average credit-adjusted risk free rate of 2.1% (2009 - 4.2%). Payments to settle the ARO are expected to occur by 2014. AHS has identified the existence of asbestos in other buildings which is not required to be remediated at this time and therefore is not recorded as an obligation.

(b) Life Lease Deposits

Funding for the Laurier House facilities, a project for long-term care residents in Edmonton, is provided by the tenants with a non-interest bearing repayment deposit, for the right to occupy the unit they are leasing. When the life lease agreement is terminated, which may be by death of the tenant or the tenant moving out, the life lease deposit is returned to the tenant without interest and in accordance with the terms of the Life Lease Agreement. The liability for life lease deposits is based on a discharge rate of 25% and a discount rate of 2.0%, representing the bank secured lending rate. The reported liability is based on estimates and assumptions with respect to events extending over a 4 year period using the best information available to management.

Note 14 Other Liabilities

(c) Supplemental Pension Plans

As of April 1, 2009 there were seven SPPs sponsored by AHS. These plans were either funded, secured by letters of credit, or unfunded. Each plan was closed to new entrants effective April 1, 2009 and during the ensuing fiscal year, the SPPs were consolidated into three funded SPPs. Under the terms of the three SPPs, participants will receive retirement benefits that supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). As required under the plans' terms, any unfunded obligations identified in the actuarial valuation completed at the end of each fiscal year must be fully funded within 61 days. The accounting policies for SPPs are described in Note (2 (i)).

	2010	2009		
	Total Plans with a surplus	Plans with a surplus	Plans with a deficit	Total
Change in accrued benefit obligation				
Accrued benefit obligation, beginning of year	$ 28,715	$ 8,565	$ 22,294	$ 30,859
Accrued benefit obligation, Nov 1, 2009 (HBA Services)	-	491	-	491
Service cost	1,701	748	1,809	2,557
Interest cost	2,000	465	1,249	1,714
Past service cost	-	-	187	187
Benefit payments	(3,224)	(1,229)	(2,736)	(3,965)
Actuarial losses (gains)	2,617	(1,113)	(2,015)	(3,128)
Accrued benefit obligation, end of year	$ 31,809	$ 7,927	$ 20,788	$ 28,715
Change in plan assets				
Fair value of plan assets, beginning of year	$ 10,178	$ 7,427	$ 981	$ 8,408
Fair value of plan assets, Nov 1, 2009 (HBA Services)	-	711	-	711
Adjustment to opening value	-	3	-	3
Actual return on plan assets	510	(314)	-	(314)
Actual employer contributions	24,903	2,433	2,948	5,381
Actual plan expenses	-	-	(46)	(46)
Benefit payments	(3,224)	(1,229)	(2,736)	(3,965)
Fair value of plan assets, end of year	$ 32,367	$ 9,031	$ 1,147	$ 10,178
Reconciliation of funded status to accrued benefit asset/liability				
Funded status of the plan	$ 558	$ 1,104	$ (19,641)	$ (18,537)
Unrecognized net actuarial losses	4,334	463	1,626	2,089
Unrecognized initial obligations	512	559	219	778
Unrecognized past service cost	776	334	845	1,179
Accrued benefit asset (liability), end of year	$ 6,180	$ 2,460	$ (16,951)	$ (14,491)

Note 14 Other Liabilities (continued)

	2010	2009		
	Total Plans with a surplus	Plans with a surplus	Plans with a deficit	Total
Determination of net benefit cost				
Service cost	$ 1,701	$ 748	$ 1,809	$ 2,557
Interest cost	2,000	465	1,249	1,714
Actual return on assets	(510)	314	-	314
Actual prior service cost in year	-	-	187	187
Actuarial losses (gains) in year	2,617	(1,117)	(2,015)	(3,132)
Amortization of initial obligations	264	641	128	769
Difference between expected and actual return on assets	224	(536)	-	(536)
Difference between recognized and actual actuarial gains/losses	(2,468)	1,573	2,921	4,494
Difference between recognized and actual past service costs	405	112	359	471
Net benefit cost	$ 4,233	$ 2,200	$ 4,638	$ 6,838
Members				
Active	64			80
Retired and terminated	55			51
Total members	119			131
Assumptions				
Weighted average discount rate to determine year end obligations	5.40%	6.20%	6.56%	6.46%
Weighted average discount rate to determine net benefit costs	6.38%	5.17%	5.33%	5.28%
Expected return on assets	2.70%	3.10%	0.00%	0.86%
Expected average remaining service life time	5	8	6	6
Rate of compensation increase	Note [i]	4.00%	4.33%	4.28%

[i] 1.5% per year for 2010 – 2011
3.2% per year for 2012 – 2014
3.5% per year thereafter

Note 15 Pension Expense

	2010	2009
Registered benefit plans [a]	$ 300,513	$ 249,614
Costs to transfer employees to LAPP	33,000	7,000
Defined contribution pension plans	11,326	9,808
Supplemental Pension Plans	4,233	6,838
	$ 349,072	$ 273,260

(a) Registered Benefit Plans

AHS participates in the Local Authorities Pension Plan (LAPP) and the Management Employee Pension Plan (MEPP), which are multi-employer defined benefit plans. The pension expense recorded in these consolidated financial statements is equivalent to AHS's contributions to the plan during the year as determined by LAPP and MEPP. At December 31, 2009 LAPP reported a deficiency of $3,998,614 (2008 - deficiency of $4,413,971), and MEPP reported a deficiency of $483,199 (2008 – $568,574).

Note 16 Accumulated Surplus/(Deficit)

AHS reported an accumulated deficit at March 31, 2010. Per Alberta Regulation 15/95 of the *Regional Health Authorities Act* (Alberta), AHS will provide the Minister with a plan in writing to eliminate the accumulated deficit within three years of incurrence.

The Province announced on February 9, 2010 that it would fund AHS's accumulated deficit as at March 31, 2010.

Note 17 Endowments

	2010	2009
Alberta Cancer Research Institute Director Research Chair [a]	$ 10,000	$ 10,000
J.K. Bigelow Education Fund [b]	150	150
	$ 10,150	$ 10,150

(a) The Alberta Cancer Research Institute (ACRI) Director Research Chair endowment is internally restricted and is designated for use as a Research Chair for the Director of ACRI. The principal amount of $10,000 is required to be maintained and all investment proceeds are available for use. Investment proceeds from the fund are recorded as a deferred contribution until used for the salary, infrastructure and operating grant support for the ACRI Director Research Chair.

Note 17 Endowments (continued)

(b) The J.K. Bigelow Education Fund endowment is internally restricted and is designated for funding of health related courses undertaken by employees of AHS in the Lethbridge area. The principal amount of $150 is required to be maintained and all investment proceeds are available for use. Investment proceeds are recorded as deferred contributions until used for education.

Note 18 Commitments and Contingencies

(a) Leases

AHS is contractually committed to future operating lease payments for premises until 2029 as follows:

Year ending March 31		
2011	$	43,799
2012		40,412
2013		35,070
2014		25,986
2015		21,441
Thereafter		63,736
	$	230,444

(b) Capital Assets

AHS has the following outstanding contractual commitments for capital assets as of March 31:

		2010
Facilities and improvements	$	1,595,077
Information systems		28,340
Equipment		48,974
	$	1,672,391

(c) Contracted Health Service Providers

AHS contracts on an ongoing basis with voluntary and private health service providers to provide health services in the Province as disclosed in Note 19 (d). AHS has contracted for services in the year ending March 31, 2011 similar to those provided by these providers in 2010.

Note 18 Commitments and Contingencies (continued)

(d) Contingencies

AHS has been named as a defendant in a legal action in respect of increased long-term care accommodation charges levied effective August 1, 2003. The claim has been filed against the Government of Alberta and the former Regional Health Authorities (now AHS). The amount of the claim has not been specified but has been estimated to be between $100 million and $175 million per year based on the amount of the increase in accommodation charges levied, which came into effect August 1, 2003. The outcome of the claim is not determinable and no liability is recorded at this time.

AHS has a contingent liability in respect of claims relating to the failure of St. Joseph's Hospital to provide adequate infection control and safety measures to prevent contamination of medical equipment. The total amount of these claims is in excess of $25 million. The outcome of the claims is not determinable, and no liability is recorded at this time.

As at March 31, 2010 AHS is named as a defendant in 379 legal claims (2009 – 356 legal claims). 329 of these claims have specified amounts totaling $1,306,699 and the remaining 50 have no specified amount. Included in the total legal claims are 7 claims amounting to $93,965 in which AHS has been jointly named with other entities. 345 claims amounting to $1,283,095 are covered by the Liability and Property Insurance Plan subject to the limits described in Note 19(f). The resulting loss, if any, from these claims cannot be determined, and therefore no liability is recorded at this time.

Note 19 Related Parties

Transactions with the following related parties are considered to be in the normal course of operations. Amounts due to or from the related parties and the recorded amounts of the transactions are included within these consolidated financial statements, unless otherwise stated.

(a) Government of Alberta

The Minister of Health and Wellness appoints the AHS Board members. Transactions between AHS and AHW are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements.

AHS shares a common relationship and is considered to be a related party with other ministries through its relationship with the Government of Alberta. Transactions in the normal course of operations between AHS and the other ministries are recorded at their exchange amount as follows:

Note 19 Related Parties (continued)

	Revenue		Expenses	
	2010	2009	2010	2009
Ministry of Advanced Education	$ 24,098	$ 30,839	$ 110,804	$ 110,344
Other Ministries	11,863	11,057	13,575	12,748
Total for the year	$ 35,961	$ 41,896	$ 124,379	$ 123,092

	Receivable from		Payable to	
	2010	2009	2010	2009
Ministry of Advanced Education	$ 2,662	$ 147	$ 10,646	$ 12,734
Other Ministries	1,863	2,550	49	4,669
Balance at end of the year	$ 4,525	$ 2,697	$ 10,695	$ 17,403

Most of AHS transactions with the Ministry of Advanced Education relate to initiatives with the University of Alberta and the University of Calgary. These initiatives include teaching, research, and program delivery. A number of physicians are employed by either AHS or the universities but perform services for both. Due to proximity of locations, some initiatives result in sharing physical space and support services. The revenue and expense transactions are a result of grants provided from one to the other and recoveries of shared costs.

(b) Primary Care Networks

AHS has joint control with various physician groups over Primary Care Networks (PCN). AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services, to achieve the PCN business plan objectives, and to contract and hold property interests required in the delivery of PCN services. Both parties have equal share ownership and equal Board representation. The following PCNs are included in these consolidated financial statements under the proportionate consolidation method:

Note 19 Related Parties (continued)

Alberta Heartland Primary Care Network	Mosaic Primary Care Network
Big Country Primary Care Network	Northwest Primary Care Network
Bonnyville / Aspen Primary Care Network	Palliser Primary Care Network
Bow Valley Primary Care Network	Peace River Primary Care Network
Calgary Foothills Primary Care Network	Provost – Consort Primary Care Network
Calgary Rural Primary Care Network	Red Deer Primary Care Network
Calgary West Central Primary Care Network	Rocky Mountain House Primary Care Network
Camrose Local Primary Care Initiative	Sexsmith Primary Care Network
Chinook Primary Care Network	Sherwood Park Primary Care Network
Edmonton North Primary Care Network	South Calgary Primary Care Network
Edmonton Oliver Primary Care Network	St. Albert and Sturgeon Primary Care Network
Edmonton Southside Primary Care Network	St. Paul / Aspen Primary Care Network
Edmonton West Primary Care Network	West Peace Primary Care Network
Highland Primary Care Network	Westview Primary Care Network
Leduc Beaumont Devon Primary Care Network	Wolf Creek Primary Care Network
MacLeod River Primary Care Network	Wood Buffalo Primary Care Network

AHS's proportionate share of AHW's contribution to PCNs are as follows:

	2010	2009
Opening balance of deferred contributions	$ 39,194	$ 37,135
Contributions from AHW	56,788	41,932
Contributions recognized as revenue	(54,156)	(39,873)
Closing balance of deferred contributions	$ 41,826	$ 39,194

Note 19 Related Parties (continued)

(c) Foundations

A large number of foundations provide donations of money and services to AHS to enhance health care in various communities throughout the Province. This financial support to AHS is reflected in donations revenue and capital contributions. These foundations are registered charities under the Income Tax Act (Canada) and accordingly, are exempt from income taxes, provided certain requirements of the Income Tax Act are met.

(i) Controlled foundations

A number of foundations are considered to be controlled entities as AHS appoints all trustees for such foundations. Controlled foundations are not consolidated in these financial statements.

The Alberta Cancer Foundation (ACF) and the Calgary Health Trust (CHT) are the most significant controlled foundations. The following aggregated financial information of ACF and CHT is presented using the same accounting policies as AHS:

	2010		2009	
	ACF	CHT	ACF	CHT
Revenue	$ 27,263	$ 59,456	$ 20,130	$ 51,530
Expenses	29,420	58,146	21,505	50,518
Excess (deficiency) of revenue over expenses	$ (2,157)	$ 1,310	$ (1,375)	$ 1,012
Total assets	$ 95,634	$ 88,448	$ 81,087	$ 95,675
Total liabilities	28,835	68,670	23,776	80,886
Net assets	$ 66,799	$ 19,778	$ 57,311	$ 14,789

Note 19 Related Parties (continued)

Financial information for the remaining controlled foundations is not disclosed because AHS does not receive financial information from all these foundations on a timely basis and the cost and effort of preparing financial information for disclosure exceeds the benefit of doing so. These foundations are immaterial organizations individually and in aggregate relative to AHS. The following are the remaining foundations controlled by AHS as at March 31, 2010:

Alberta Hospital Edmonton and Community Mental Health Foundation
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Canmore and Area Health Care Foundation
Capital Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grand Cache Hospital Foundation
Grimshaw/Berwyn Hospital Foundation
Jasper Health Care Foundation
Medicine Hat and District Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Viking Health Foundation
Windy Slopes Health Foundation

Note 19 Related Parties (continued)

The following foundations are also considered controlled, but are in the process of being wound-up or are considered to be inactive:

Central Peace Hospital Foundation
Peace Health Region Foundation
Manning Community Health Centre Foundation
McLennan Community Health Care Foundation
Lakeland Regional Health Authority Foundation

(ii) Other foundations

AHS has an economic interest in a number of foundations as they raise and hold resources to support AHS. AHS appoints one board trustee for such foundations. Financial information for these foundations is not disclosed because AHS does not receive financial information from all these foundations on a consistent and timely basis and the cost and effort of preparing financial information for disclosure exceeds the benefit of doing so. The following are the foundations that AHS has an economic interest in as of March 31, 2010:

Alberta Children's Hospital Foundation
Beaverlodge Hospital Foundation
Black Gold Health Foundation
Chinook Regional Hospital Foundation
Consort Hospital Foundation
Coronation Heath Centre Foundation
Daysland Hospital Foundation
Devon General Hospital Foundation
Drayton Valley Health Services Foundation
Drumheller Area Health Foundation
Fairview Health Complex Foundation
Glenrose Rehabilitation Hospital Foundation
High River District Health Care Foundation
Hinton Health Care Foundation
Hythe Nursing Home Foundation
Northern Lights Regional Health Foundation
Northwest Health Foundation
Queen Elizabeth II Hospital Foundation
Rosebud Health Foundation
Royal Alexandra Hospital Foundation
Sheep River Health Trust
St. Paul and District Hospital Foundation
Stettler Health Services Foundation
Stollery Children's Hospital Foundation
Strathmore District Health Foundation
Sturgeon Community Hospital Foundation
Taber and District Health Foundation
Tri-Community Health and Wellness Foundation
University Hospital Foundation
Valleyview Health Centre Foundation
Wainwright and District Community Foundation
Wetaskiwin Health Foundation

Note 19 Related Parties (continued)

(d) Contracts with Health Service Providers

AHS is responsible for the delivery of health services in the Province. To this end, AHS contracts with various private and voluntary health service providers to continue to provide health services throughout the Province. The largest of these service providers is Covenant Health; the total amount funded to Covenant Health during the year was $551,098 (2009 - $503,678). As of March 31, 2010, the net book value of assets owned by AHS but operated by a voluntary or private health service provider was $141,844 (2009 - $141,374).

AHS has an economic interest through its contracts with certain voluntary and private health service providers as AHS transfers significant resources as follows:

	2010			2009		
	Voluntary Health Service Providers	Private Health Service Providers	Total	Voluntary Health Service Providers	Private Health Service Providers	Total
Direct AHS funding	$816,197	$778,183	$1,594,380	$793,723	$649,703	$1,443,426
Direct AHW funding	-	986	986	-	1,219	1,219
Fees and charges	95,490	94,284	189,774	94,884	86,552	181,436
Full cost adjustments	14,387	83	14,470	14,288	82	14,370
Total	$926,074	$873,536	$1,799,610	$902,895	$737,556	$1,640,451

(e) Health Organizations Benefit Plan

AHS is a participant in the Health Organizations Benefit Plan (HOBP) which is a formal health and welfare trust established under a Trust Agreement effective January 1, 2000. HOBP provides health and other related employee benefits pursuant to the authorizing Trust Agreement. HOBP uses various carriers for the different benefits. As a trust, HOBP is exempt from the payment of income taxes.

AHS is one of more than thirty participants in HOBP and has the majority of representation on HOBP's governance board. It is recognized that as individuals and as the HOBP board collectively, the board has a fiduciary duty to act in the best interest of all participants and HOBP itself.

Under the terms of the Trust Agreement, no participating employer or eligible employee shall have any right to any surplus or assets of the Trust nor shall they be responsible for any deficits or liabilities of the Trust. HOBP maintains various reserves to adequately provide for all current obligations, and reported fund balances of $29,594 as at December 31, 2009 ($19,339 as at December 31, 2008). AHS paid premiums of $38,159 (2009 - $30,663).

Note 19 Related Parties (continued)

(f) Liability and Property Insurance Plan

AHS is a subscriber to the Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP) which is a reciprocal insurance exchange duly established under the *Insurance Act* (Alberta). The main purpose of LPIP is to share the risks of liability to lessen the impact on any one subscriber. LPIP is administered pursuant to the terms and conditions of the Reciprocal Insurance Exchange Agreement to which all subscribers are signatories. As a reciprocal LPIP is exempt from the payment of income tax but is subject to the provincial premium tax.

LPIP provides its subscribers with general and professional liability coverage and insures some of its subscriber's buildings and contents. AHS claims are subject to a maximum limit of $5 million per occurrence with an additional $5 million limit per occurrence. The additional limit is subject to an absolute limit of $15 million in aggregate for all occurrences for each policy year. Claims in excess of these limits are the responsibility of AHS as the subscriber. Neither AHS nor LPIP purchase any reinsurance.

Under the terms of the agreement, in the event that LPIP has accumulated funds in excess of those required to meet its obligations, those funds may be invested to accrue to the benefit of LPIP, provided in the form of a cash dividend to its subscribers, or applied to reduce premiums to LPIP in any subsequent underwriting year. As per the Insurance Act, LPIP maintains a reserve fund and a guarantee fund. If there are insufficient funds, LPIP will collect such additional assessments from its subscribers as required.

The most recent financial results of LPIP are as follows:

	December 31, 2009	December 31, 2008
Total assets	$ 87,468	$ 75,959
Total liabilities	73,605	61,534
Net assets	$ 13,863	$ 14,425
Revenues	$ 12,332	$ 11,950
Expenses	19,714	15,439
Underwriting loss	(7,382)	(3,489)
Investment income/(loss)	6,820	(1,249)
Net loss	$ (562)	$ (4,738)

Included in liabilities is an actuarial provision for losses of $68,865 (2008 - $58,193). $51,275 (2008 – $44,892) of this provision is for liabilities incurred but not reported. Included in revenues are premiums paid by AHS of $9,746 (2008 - $9,461).

Note 19 Related Parties (continued)

AHS is one of more than fifty subscribers to LPIP and has the majority of representation on LPIP's governance board. It is recognized that as individuals and as the LPIP board collectively, the board has a fiduciary duty to act in the best interest of all subscribers and LPIP itself.

Note 20 Trust Funds

AHS receives funds in trust from AHW that are to be paid to operators of non-owned facilities for capital purposes or facility repairs, and for specific projects. In addition, AHS receives funds in trust for research and development, education and other programs. AHS receives funds in trust from AHW for some Primary Care Networks; AHS uses these funds to cover the Primary Care Networks' expenditures until they make their own banking arrangements. These amounts are not reported in these consolidated financial statements. As at March 31, 2010, the balance of funds held by AHS is as follows:

	2010	2009
AHW	$ 694	$ 12,723
Research and development, education and other programs	6,558	7,081
Primary Care Networks	3,943	3,159
	$ 11,195	$ 22,963

AHS also receives funds in trust from continuing care residents for personal expenses. These amounts are not included above and not reflected in these consolidated financial statements.

Note 21 Approval of Consolidated Financial Statements

The consolidated financial statements have been approved by the Alberta Health Services Board.

CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT
FOR THE YEAR ENDED MARCH 31, 2010

	2010		2009
	Budget (Note 3)	Actual	Actual (Note 4 (b))
Salaries and benefits (Schedule 2)	$ 5,493,130	$ 5,483,260	$ 5,021,985
Contracts with health service providers (Note 19 (d))	1,716,568	1,799,610	1,640,451
Contracts under the Health Care Protection Act	23,855	23,866	22,125
Drugs and gases	334,595	332,600	317,163
Medical and surgical supplies	336,491	320,135	321,173
Other contracted services	1,148,410	1,101,908	921,762
Other *	1,195,176	1,004,079	1,069,552
Amortization:			
Equipment – internally funded	81,265	81,985	80,670
Equipment – externally funded	149,405	169,909	153,509
Facilities and improvements – internally funded	14,354	24,474	18,995
Facilities and improvements – externally funded	144,531	132,171	148,826
Loss on disposal of assets	15,081	364	11,841
Capital assets write down (Note 9 (c))	-	2,682	13,810
	$10,652,861	$ 10,477,043	$ 9,741,862
* Significant amounts included in Other are:			
Other clinical supplies	$ 114,666	$ 119,717	$ 116,380
Utilities	120,994	94,622	113,345
Equipment and software maintenance	101,312	94,429	91,131
Minor equipment purchases	43,578	73,139	66,141
Rent	69,849	72,815	59,099
Food supplies	70,126	68,397	69,796
Travel	94,778	66,066	104,553

Alberta Health Services

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2010

	2010								2009	
						Severance [e]				
	Number of FTE's [a]	Base Salary [b]	Other Cash Benefits [c]	Non-Cash Benefits [d][f]	Subtotal	Number of Individuals	Amount	Total	FTE's [a]	Total
Board Chair										
Ken Hughes	1.00	$ -	$ 104	$ -	$ 104	-	$-	$ 104	0.88	$ 77
Board Members										
Jack Ady	1.00	-	62	-	62	-	-	62	0.88	49
Lori Andreachuk	1.00	-	61	-	61	-	-	61	0.33	20
Gord Bontje	1.00	-	60	-	60	-	-	60	0.33	22
Teri Lynn Bougie	1.00	-	61	-	61	-	-	61	0.33	20
Jim Clifford	1.00	-	61	-	61	-	-	61	0.33	23
Strater Crowfoot	1.00	-	59	-	59	-	-	59	0.33	22
Tony Franceschini	1.00	-	58	-	58	-	-	58	0.33	20
Linda Hohol	1.00	-	59	-	59	-	-	59	0.88	48
Andreas Laupacis	1.00	-	60	-	60	-	-	60	0.33	20
John Lehners	1.00	-	65	-	65	-	-	65	0.88	49
Irene Lewis	1.00	-	60	-	60	-	-	60	0.88	49
Catherine Roozen	1.00	-	53	-	53	-	-	53	0.63	27
Don Sieben	1.00	-	75	-	75	-	-	75	0.88	51
Gord Winkel	1.00	-	-	-	-	-	-	-	0.33	-
Pierre Crevolin	-	-	-	-	-	-	-	-	0.21	10
Board members of former health authorities and boards	-	-	-	-	-	-	-	-	14.84	482
Total Board	15.00	$ -	$ 898	$ -	$ 898	-	$ -	$ 898	23.60	$ 989

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2010

	2010								2009	
						Severance [e]				
	Number of FTE's [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d][f]	Subtotal	Number of Individuals	Amount	Total	Number of FTE's [a]	Total
Board Direct Reports										
President and Chief Executive Officer [g][h][aa]	1.00	$ 595	$139	$ 10	$ 744	-	$ -	$ 744	0.02	$ 116
Interim Chief Executive Officer	-	-	-	-	-	-	-	-	0.88	481
Interim VP Internal Audit and Enterprise Risk Management – Contracted Services	0.09	42	-	-	42	-	-	42	-	-
VP Internal Audit and Enterprise Risk Management [n][bb]	0.52	121	31	52	204	1.00	362	566	0.85	280
VP Internal Audit and Enterprise Risk Management [n]	0.42	81	6	17	104	-	-	104	-	-
Ethics and Compliance Officer [m]	0.98	216	2	31	249	-	-	249	-	-
Board direct reports of former health authorities and boards	-	-	-	-	-	-	-	-	13.28	15,258
CEO Direct Reports										
Executive VP and Chief Financial Officer [h] [r][bb]	0.97	372	89	31	492	-	-	492	-	-
Executive VP, Corporate Services [h] [q][bb]	0.74	289	81	23	393	-	-	393	-	-
Acting Executive VP, Corporate Services [p][q]	0.33	65	-	16	81	-	-	81	0.33	91
Executive VP, Quality and Service Improvement [h][j][l][t][ee]	1.00	486	111	215	812	-	-	812	1.00	825
Executive VP, Rural, Public and Community Health [l][w][dd]	1.00	374	60	87	521	-	-	521	1.00	717
Executive VP, Strategy and Performance [h][l][bb]	0.41	158	67	21	246	-	-	246	-	-
Acting Executive VP, Strategy and Performance [h][j][l][s][bb]	0.75	257	102	62	421	1.00	61	482	1.00	978
Senior VP, Clinical Support Services [l][v][ee]	1.00	329	47	50	426	-	-	426	1.00	390
Senior Physician Executive [l][m][ff]	1.00	499	86	141	726	-	-	726	1.00	700
VP Community Engagement and Chief of Staff, Board Office [k][x][gg]	0.37	57	12	9	78	-	-	78	-	-
Chief of Staff, Board Office [y][bb]	0.58	112	33	34	179	-	-	179	-	-
Interim Chief Operating Officer, Health Strategies, Research and Design [s][bb]	0.08	29	14	46	89	-	-	89	1.00	745
Interim Chief Operating Officer, Corporate Services	-	-	-	-	-	-	-	-	0.45	187
Executive Operating Officer, Continuum of Care	-	-	-	-	-	-	-	-	0.71	1,861
Interim Chief Financial Officer	-	-	-	-	-	-	-	-	1.00	1,854
CEO direct reports of former health authorities and boards	-	-	-	-	-	-	-	-	58.25	21,398
Total Executive	11.24	$4,082	$ 880	$ 845	$ 5,807	2.00	$ 423	$ 6,230	81.77	$ 45,881

Alberta Health Services

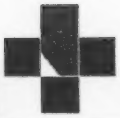
CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2010

	2010								2009	
						Severance [e]				
	Number of FTE's [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d][f]	Subtotal	Number of Individuals	Amount	Total	Number of FTE's [a]	Total
Management reporting to CEO direct reports	42.78	$ 8,987	$ 698	$ 1,006	$ 10,691	3.00	$ 495	$ 11,186	1,613.10	$ 199,311
Other management	3,472.32	341,622	18,897	70,959	431,478	233.00	23,601	455,079	2,000.00	229,833
Medical doctors not included above	172.44	39,246	1,915	1,784	42,945	-	-	42,945	145.80	38,293
Regulated nurses not included above										
RNs, Reg. Psych. Nurses, Grad Nurses	16,764.59	1,393,227	147,697	260,926	1,801,850	448.00	23,644	1,825,494	16,798.32	1,703,557
LPNs	3,307.90	185,382	17,459	33,571	236,412	4.00	214	236,626	3,173.29	212,174
Other health technical and professional	12,580.79	920,933	62,565	182,842	1,166,340	69.00	2,433	1,168,773	11,514.77	1,009,512
Unregulated health service providers	6,047.78	256,139	17,952	46,315	320,406	18.00	866	321,272	5,923.17	288,813
Other staff	22,132.96	1,094,576	56,952	220,702	1,372,230	143.00	9,527	1,381,757	21,945.59	1,286,622
Costs to transfer employees to LAPP	-	-	-	33,000	33,000	-	-	33,000	-	7,000
	64,521.56	4,240,112	324,135	851,105	5,415,352	918.00	60,780	5,476,132	63,114.04	4,975,115
Total	64,547.80	$4,244,194	$325,913	$851,950	$5,422,057	920.00	$61,203	$5,483,260	63,219.41	$ 5,021,985

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2010

Supplemental Pension Plan (SPP)

	2010			2009			
	Current Service Cost	Other SERP Costs	Total	Total	Accrued Benefit Obligation March 31, 2009	Change in Accrued Benefit Obligation	Accrued Benefit Obligation March 31, 2010
President and Chief Executive Officer	$ -	$ -	$-	$ -	$ -	$ -	$ -
Interim VP Internal Audit and Enterprise Risk Management – Contracted Service	-	-	-	-	-	-	-
VP Internal Audit and Enterprise Risk Management[a]	26	17	43	37	197	8	205
VP Internal Audit and Enterprise Risk Management[a]	-	-	-	-	-	-	-
Ethics and Compliance Officer	-	-	-	-	-	-	-
Executive VP and Chief Financial Officer	-	-	-	-	-	-	-
Executive VP, Corporate Services	-	-	-	-	-	-	-
Acting Executive VP, Corporate Services	-	-	-	-	-	-	-
Executive VP, Quality and Service Improvement	95	84	179	199	915	225	1,140
Executive VP, Rural, Public and Community Health	28	34	62	310	394	244	638
Executive VP, Strategy and Performance	-	-	-	-	-	-	-
Acting Executive VP, Strategy and Performance	30	16	46	26	141	(32)	109
Senior VP, Clinical Support Services	24	3	27	31	49	31	80
Senior Physician Executive	79	30	109	97	334	57	391
VP Community Engagement and Chief of Staff, Board Office	-	-	-	-	-	-	-
Chief of Staff, Board Office	17	8	25	29	87	(87)	-
Interim Chief Operating Officer, Health Strategies, Research and Design	37	9	46	53	210	15	225



Alberta Health Services

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2010

a. Full time equivalents (FTE's) for Board Members are prorated using the number of days in the fiscal year between either the date of appointment or termination date (if applicable) and the end of the year. FTE's for staff are determined at the rate of 2,022.75 annual hours for each full-time employee. Total actual discrete number of individuals employed during the fiscal year was 94,715.

b. Base salary includes pensionable base pay as well as statutory and vacation accruals relating to the current fiscal year.

c. Other cash benefits include honoraria, bonuses, overtime, vacation payouts and lump sum payments.

d. Other non-cash benefits include:
- Employer's current and prior service cost of supplemental pension plans [f].
- Share of all employee benefits and contributions or payments made on behalf of employees including pension, health care, dental coverage, vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short term disability plans.
- Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

e. Severance includes direct or indirect payments to individuals upon termination or voluntary exit, which are not included in other cash benefits.

f. Supplemental Pension Plans (SPP)

Under the SPP certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service post 1991 based on the employee's service and earnings. The SPP costs are not cash payments in the period but are the cost for the period for rights to these future retirement benefits. Current service cost is the actuarial present value of the benefits earned in the fiscal year. Other SPP costs include interest cost on the obligations and current service cost, the amortization of past service cost, initial obligations and net actuarial gains and losses, offset by the expected return on the plans' assets. Changes in the accrued benefit obligation include current service cost, interest accruing on the obligations and the current service cost as well as the full amount of any actuarial gains or losses in the period. The SPP is disclosed in Notes 2(i) and 14(c).

g. Incumbent's other non-cash benefits include an amount for the maximum contribution to a registered retirement savings plan. Upon the completion of each five full years of employment the incumbent will be entitled to one year of paid sabbatical leave. An amount will be recorded in the accounts of AHS at the end of each full five years of employment.

h. Incumbents are provided with an automobile allowance. Dollar amounts are included in other cash benefits [e].

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2010

i. Incumbents are provided with an automobile. Dollar amounts are not included in other non-cash benefits [(4)].

j. Incumbent's other cash benefits include a lump-sum retroactive premium payment relating to the prior year.

k. Incumbent's other cash benefits include a lump-sum retroactive salary payment relating to the prior year.

l. Incumbent is on secondment from the University of Calgary. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary, honorarium and market supplements; all amounts have been included in base salary.

m. Incumbent is on secondment from the University of Calgary. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary; all amounts have been included in base salary.

Appointments and Departures

n. Position held by incumbent until October 9, 2009.

o. Position held by incumbent from October 5, 2009 until March 5, 2010.

p. Incumbent held the position of Special Assistant to the Chief Operating Officer, Corporate Services until May 12, 2009 at which time the incumbent was appointed to Acting Executive VP, Corporate Services until July 31, 2009.

q. From July 6 – 31, 2009 this position was held by two incumbents as the acting incumbent [(p)] remained on acting in a transitional capacity until that date.

r. Incumbent held the position of Chief Operating Officer, Urban until May 12, 2009 at which time the position was eliminated and the incumbent was appointed to Executive VP, Quality and Service Improvement.

s. Incumbent appointed to position effective April 14, 2009.

t. Incumbent appointed to position effective November 4, 2009.

u. Incumbent held the position of Interim Chief Operating Officer, Change Management until May 12, 2009 at which time the position was eliminated and the incumbent was appointed to the position of Acting Executive VP, Strategy and Performance until November 4, 2009. The incumbent held two other positions throughout the year: Acting Executive VP and Chief Financial Officer (April 1 – 14, 2009) and Special Assistant to the Chief Executive Officer, Corporate Services (May 12, 2009 – January 2, 2010). The Special Assistant position has been vacant since the incumbent's departure.

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2010

v. Incumbent held the position of Chief Operating Officer, Performance Improvement and Clinical Support Services until May 12, 2009 at which time the position was eliminated and the incumbent was appointed to Senior VP, Clinical Support Services.

w. Incumbent held the position of Chief Operating Officer, Community and Rural until May 12, 2009 at which time the position was eliminated and the incumbent was appointed to Executive VP, Rural, Public and Community Health.

x. Incumbent appointed to position effective November 2, 2009.

y. Position held by incumbent until November 2, 2009.

z. Position held by incumbent until April 30, 2009 at which time the position was eliminated.

Termination Liabilities

aa. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 12 months base salary at the rate in effect at the date of termination. The incumbent will also be paid 15% of the severance in lieu of all other benefits as well as relocation expenses not to exceed $20,000.

bb. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 12 months base salary at the rate in effect at the date of termination. The incumbent will also be paid 15% of the severance in lieu of all other benefits.

cc. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive a maximum severance pay of 17 months base salary[(l)] and premium payments at the rate in effect at the date of termination. The incumbent will also receive the incentive bonus for the prior two years divided by 24 months multiplied by a maximum of 17 months and up to 17 months of the total cost of the incumbent's benefits. AHS will also make payment for the incumbent to attend an outplacement program for 6 months.

CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2010

dd. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 24 months base salary at the rate in effect at the date of termination. The incumbent will also be paid an amount equal to 24 months of AHS's cost of benefits.

ee. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will be provided with a severance package equivalent to 12 months salary and benefits plus one additional month per year of service provided to a maximum of 24 months.

ff. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to a maximum of 18 months base salary [m] and premium payments at the rate in effect at the date of termination. The incumbent will also be paid an amount up to 18 months of the total cost of the incumbent's benefits. AHS will also make payment for the incumbent to attend an outplacement program for 6 months.

gg. The incumbent's termination benefits have not been predetermined.

hh. Based on the provisions of the applicable SPP [f], the following outlines the benefits received by individuals who departed within the 2009-2010 fiscal period:

Position	Benefit (not in thousands)	Frequency	Payment Terms
VP Internal Audit and Enterprise Risk Management [n]	$ 1,170	Monthly	Indefinite
Acting Executive VP, Strategy and Performance	110,067	Lump-Sum	One-Time
Chief of Staff, Board Office	92,720	Lump-Sum	One-Time
Interim Chief Operating Officer, Health Strategies, Research and Design	1,341	Monthly	Indefinite

CONSOLIDATED SCHEDULE OF BUDGET
FOR THE YEAR ENDED MARCH 31, 2010

	Original Financial Plan	Additional Reclassifications	Reported Budget
Revenue			
Alberta Health and Wellness contributions	$ 8,399,000	$ 31,022	$ 8,430,022
Other government contributions	70,000	10,980	80,980
Fees and charges	575,000	9,991	584,991
Ancillary operations	113,000	(4,419)	108,581
Donations	19,000	(3,332)	15,668
Investment and other income	286,000	(39,016)	246,984
Amortization of external capital contributions	300,000	635	300,635
TOTAL REVENUE	9,762,000	5,861	9,767,861
Expenses			
Inpatient acute nursing services	2,575,000	158,440	2,733,440
Emergency and outpatient services	1,199,000	(52,619)	1,146,381
Facility-based continuing care services	872,000	(84,138)	787,862
Ambulance services	329,000	(13,082)	315,918
Community-based care	603,000	127,069	730,069
Home care	388,000	(20,193)	367,807
Diagnostic and therapeutic services	1,806,000	(82,992)	1,723,008
Promotion, prevention and protection services	345,000	(4,611)	340,389
Research and education	256,000	(52,341)	203,659
Administration	340,000	99,696	439,696
Information technology	289,000	(37,840)	251,160
Support services	1,491,000	(59,012)	1,431,988
Amortization of facilities and improvements	154,000	13,584	167,584
Funded transition costs	-	13,900	13,900
TOTAL EXPENSES	10,647,000	5,861	10,652,861
Deficiency of revenue over expenses	$ (885,000)	$ -	$ (885,000)

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF BUDGET
MARCH 31, 2010
(thousands of dollars)

	Original Financial Plan	Additional Reclassifications	Reported Budget
Expenses by object			
Salaries and benefits	$ 5,482,000	$ 11,130	$ 5,493,130
Contracts with health service providers	1,808,000	(91,432)	1,716,568
Contracts under the Heath Care Protective Act	23,000	855	23,855
Drugs and gases	386,000	(51,405)	334,595
Medical and surgical supplies	410,000	(73,509)	336,491
Other contracted services	1,014,000	134,410	1,148,410
Other	1,058,000	137,176	1,195,176
Amortization			
Equipment – internally funded	86,000	(4,735)	81,265
Equipment – externally funded	227,000	(77,595)	149,405
Facilities and improvements – internally funded	79,000	(64,646)	14,354
Facilities and improvements – externally funded	73,000	71,531	144,531
Loss on disposal of capital assets	1,000	14,081	15,081
TOTAL EXPENSES BY OBJECT	$ 10,647,000	$ 5,861	$ 10,652,861

CONSOLIDATED SCHEDULE OF COMPARATIVES
FOR THE YEAR ENDED MARCH 31, 2010

	As Previously Reported by Former Health Entities	Eliminations	Reclassifications and Adjustments	As Restated
Revenue				
Alberta Health and Wellness contributions	$ 8,224,844	$ (12,307)	$ 15,125	$ 8,227,662
Other government contributions	173,545	(82,305)	(24,594)	66,646
Fees and charges	544,417	(201)	(1,600)	542,616
Ancillary operations	115,329	-	2,323	117,652
Donations	24,959	-	414	25,373
Research and education	58,690	-	(58,690)	-
Investment and other income	281,437	(74,453)	75,698	282,682
Amortized external capital contributions	323,009	-	(79)	322,930
TOTAL REVENUE	$ 9,746,230	$ (169,266)	$ 8,597	$ 9,585,561
Expenses				
Inpatient acute nursing services	$ 2,421,861	$ (19,938)	$ (3,172)	$ 2,398,751
Emergency and outpatient services	1,142,718	(17,510)	(26,002)	1,099,206
Facility-based continuing care services	759,204	(282)	(2,692)	756,230
Ambulance services	19,805	-	24,165	43,970
Community-based care	541,496	(34,705)	39,189	545,980
Home care	401,143	(965)	(7,019)	393,159
Diagnostic and therapeutic services	1,741,377	(25,643)	1,746	1,717,480
Promotion, prevention and protection services	298,979	(1,551)	(434)	296,994
Research and education	229,866	(816)	(1,684)	227,366
Administration	346,997	(31,967)	9,326	324,356
Information technology	290,885	(1,740)	(8,195)	280,950
Support services	1,479,952	(8,514)	(29,780)	1,441,658
Amortization of facilities and improvements	162,052	-	(661)	161,391
Capital assets write down	-	-	13,810	13,810
Funded transition costs	66,196	(25,635)	-	40,561
TOTAL EXPENSES	$ 9,902,531	$ (169,266)	$ 8,597	$ 9,741,862

SCHEDULE 4 - CONSOLIDATED SCHEDULE OF COMPARATIVES
MARCH 31, 2010
(thousands of dollars)

	As Previously Reported by Former Health Entities	Eliminations	Reclassifications and Adjustments	As Restated
Assets				
Cash	$ 1,048,310	$ -	$ 95,913	$ 1,144,223
Accounts receivable	214,797	(54,097)	(1,479)	159,221
Contributions receivable from Alberta Health and Wellness	35,671	-	512	36,183
Inventories	91,108	-	1	91,109
Prepaid expenses	46,508	(515)	51	46,044
Investments (non-current cash)	1,903,219	-	(95,900)	1,807,319
Capital assets	5,539,415	-	(8)	5,539,407
Capital contributions receivable from Alberta Health and Wellness	23,641	-	(7,141)	16,500
Contributions receivable	44,699	-	(44,699)	-
Non-current advances – continuing care partnerships	8,381	-	(8,381)	-
Loans - continuing care partnership projects	68,155	-	(68,155)	-
Other assets	33,378	(14,381)	125,789	144,786
TOTAL ASSETS	$ 9,057,282	$ (68,993)	$ (3,497)	$ 8,984,792
Liabilities				
Accounts payable and accrued liabilities	$ 969,667	$ (68,993)	$ 2,049	$ 902,723
Accrued vacation pay	339,511	-	(8,912)	330,599
Deferred contributions current	551,340	-	79,280	630,620
Current portion of long-term debt	12,717	-	(649)	12,068
Deferred contributions non-current	121,080	-	60,266	181,346
Deferred contributions – continuing care partnership projects	92,769	-	(92,769)	-
Deferred contributions – Healthy Aging Partnership	2,704	-	(2,704)	-
Deferred capital contributions	1,740,794	-	(44,018)	1,696,776
Long-term debt	190,978	-	(1,762)	189,216
Asset retirement obligation	9,928	-	(9,928)	-
Long-term employee benefit liabilities	9,429	-	(9,429)	-
Life lease deposit	13,625	-	(13,625)	-
Other liabilities	6,343	-	39,081	45,424
Unamortized external capital contributions	4,675,236	-	(6)	4,675,230
TOTAL LIABILITIES	$ 8,736,121	$ (68,993)	$ (3,126)	$ 8,664,002
Net assets [a]				
Accumulated surplus (deficit)	$ (342,818)	$ -	$ (401)	$ (343,219)
Accumulated net unrealized gains (losses) on investments	(17,738)	-	1	(17,737)
Internally restricted net assets invested in capital assets	671,265	-	331	671,596
Endowments	10,452	-	(302)	10,150
TOTAL NET ASSETS	$ 321,161	$ -	$ (371)	$ 320,790
TOTAL LIABILITIES AND NET ASSETS	$ 9,057,282	$ (68,993)	$ (3,497)	$ 8,984,792

SCHEDULE 4 - CONSOLIDATED SCHEDULE OF COMPARATIVES
MARCH 31, 2010
(thousands of dollars)

	As Previously Reported by Former Health Entities	Eliminations	Reclassifications and Adjustments	As Restated
Expense by object				
Salaries and benefits	$ 5,024,925	$ (826)	$ (2,114)	$ 5,021,985
Contracts with health service providers	1,710,784	(72,571)	2,238	1,640,451
Contracts under the Health Care Protection Act	21,255	-	870	22,125
Drugs and gases	323,374	(6,229)	18	317,163
Medical and surgical supplies	322,335	(1,043)	(119)	321,173
Other contracted services	956,909	(34,366)	(781)	921,762
Interest on long-term debt	7,091	-	(7,091)	-
Other expenses	1,058,945	(5,206)	15,813	1,069,552
Amortization				
Equipment - internally funded	80,836	-	(166)	80,670
Equipment - externally funded	153,509	-	-	153,509
Facilities and improvements - internally funded	18,995	-	-	18,995
Facilities and improvements - externally funded	148,826	-	-	148,826
Loss on disposal of assets	11,912	-	(71)	11,841
Capital assets write down	13,810	-	-	13,810
Funded transition costs	49,025	(49,025)	-	-
TOTAL EXPENSES	$ 9,902,531	$ (169,266)	$ 8,597	$ 9,741,862

(a) Net asset adjustments include:

- Transfer of expendable investment proceeds from endowments to deferred contributions.
- Transfer of previous repayments of long term debt used to fund capital assets from accumulated surplus (deficit) to internally restricted net assets invested in capital assets.

UNAUDITED CONSOLIDATED SCHEDULE OF FACILITIES AND SITES AS AT MARCH 31, 2010

The operations of the following facilities and sites are included in these financial statements:

Calgary and Area

Location	Facility		Facility Type** A/CC/P/ SL/O
Airdrie	Bethany Care Centre - Airdrie		CC
Banff	Mineral Springs Hospital		A,CC
Black Diamond	Oilfields General Hospital	*	A,CC
Calgary	Agape Hospice		CC
Calgary	Alberta Children's Hospital	*	A
Calgary	Approved Homes – Mental Health		O
Calgary	Aspen Family and Community Network (Eating Disorder Clinic)		O
Calgary	Aventa Addiction Treatment for Women		O
Calgary	Bethany Harvest Hills		CC
Calgary	Beverly Centre – Lake Midnapore		CC,SL
Calgary	Bow Crest Care Centre		CC
Calgary	Bow View Manor		CC
Calgary	Calgary Alpha House		O
Calgary	Canadian Mental Health Association		O
Calgary	Canadian Mental Health Association (Hamilton House)		O
Calgary	Carewest Dr. Vernon Fanning	*	CC
Calgary	Centre		
Calgary	Carewest George Boyack	*	CC
Calgary	Carewest Royal Park	*	CC
Calgary	Carewest Sarcee	*	CC
Calgary	Carewest Signal Pointe	*	CC
Calgary	Colonel Belcher Care Centre	*	CC,SL
Calgary	Eau Claire Retirement Residence		SL
Calgary	Edgemont Retirement Residence		SL
Calgary	Father Lacombe Care Centre		CC
Calgary	Foothills Medical Centre	*	A
Calgary	Forest Grove Care Centre		CC
Calgary	Fresh Start Recovery Centre		O
Calgary	Glamorgan Care Centre		CC
Calgary	Intercare Brentwood Care		CC
Calgary	Centre		CC
Calgary	Intercare Chinook Care Centre		CC
	Intercare Southwood Care Centre		

Location	Facility		Facility Type** A/CC/P/ SL/O
Calgary	Jackson Willan Seniors' Residence		SL
Calgary	Mayfair Care Centre		CC
Calgary	McKenzie Towne Care Centre		CC,SL
Calgary	Millrise Place		SL
Calgary	Mount Royal Care Centre		CC
Calgary	Oxford House		O
Calgary	Personal Care Homes - Continuing Care		SL
Calgary	Peter Lougheed Centre	*	A
Calgary	Recovery Acres		O
Calgary	Renfrew Recovery Centre	*	O
Calgary	Rockyview General Hospital	*	A
Calgary	Salvation Army		O
Calgary	Scenic Acres Retirement Residence		SL
Calgary	Southern Alberta Foresenic Psychiatric Centre	*	P
Calgary	Sunnyhill Wellness Centre		SL
Calgary	Sunrise Native Addiction Services Society		O
Calgary	Wing Kei Care Centre		CC
Calgary	Youth Detoxification and Residential Services	*	O
Calgary	Youville Women's Residence		O
Canmore	Canmore General Hospital	*	A,CC
Carmangay	Little Bow Continuing Care Centre	*	CC
Claresholm	Lander Treatment Centre		O
Claresholm	Claresholm Centre for Mental Health and Addictions	*	P
Claresholm	Claresholm General Hospital	*	A
Claresholm	Willow Creek Continuing Care Centre	*	CC
Didsbury	Didsbury District Health Services	*	A,CC
High River	High River General Hospital	*	A,CC
Okotoks	Foothils Country Hospice		CC
Strathmore	Strathmore District Health Services	*	A,CC
Vulcan	Extendicare Vulcan		CC
Vulcan	Vulcan Community Health Centre	*	A,CC

*Operated by AHS

** A = Acute care facility, CC = Continuing care facility, P = Psychiatric facility, SL = Supportive Living, O = Other

Camrose and Area

Location	Facility		Facility Type** A/CC/P/ SL/O
Bashaw	Bashaw Care Centre	*	CC
Camrose	Bethany Meadows		CC,SL
Camrose	Faith House		SL
Camrose	Louise Jensen Care Centre		CC
Camrose	Memory Lane		CC
Camrose	Rosehaven Care Centre		CC
Camrose	St Mary's Hospital		A
Camrose	Viewpoint		CC
Daysland	Daysland - Providence Place		SL
Daysland	Daysland Health Centre	*	A
Galahad	Galahad Care Centre	*	CC
Hardisty	Hardisty Health Centre	*	A,CC
Islay	Islay Assisted Living	*	SL
Killam	Killam Health Care Centre		A,CC
Lamont	Lamont Health Care Centre		A,CC
Lloydminster	Lloydminster - Points West Living		SL
Lloydminster	Slim Thorpe Recovery Centre		O
Mannville	Mannville Care Centre	*	CC
Mundare	Mary Immaculate Hospital		CC
Myrnam	Myrnam - Eagleview Lodge		SL
Provost	Provost Health Centre	*	A,CC,SL
Tofield	Tofield Health Centre	*	A,CC
Two Hills	Two Hills Health Centre	*	A,CC
Vegreville	Century Park	*	SL
Vegreville	Heritage House		SL
Vegreville	Vegreville Care Centre	*	CC
Vermilion	Vermilion Health Centre	*	A,CC
Vermilion	Vermilion Valley Lodge Supportive Housing		SL
Viking	Viking Extendicare		CC
Viking	Viking Health Centre	*	A
Wainwright	Wainwright Health Centre	*	A,CC

Edmonton and Area

Location	Facility		Facility Type** A/CC/P/ SL/O
Alexander Reserve	Kipohtakawmik Elders Lodge		SL
Devon	Devon General Hospital	*	A,CC
Edmonton	Henwood Treatment Centre	*	O
Edmonton	Recovery Centre	*	O
Edmonton	Youth Detoxification and Residential Services	*	O
Edmonton	Alberta Hospital Edmonton	*	P
Edmonton	All Seniors Care Rutherford		SL
Edmonton	Allen Gray Continuing Care Centre		CC
Edmonton	Capital Care - Laurier House	*	SL
Edmonton	Capital Care - McConnell Place North	*	SL
Edmonton	Capital Care - McConnell Place West	*	SL
Edmonton	Capital Care Dickensfield	*	CC
Edmonton	Capital Care Dickensfield	*	SL
Edmonton	Duplexes YAP		
Edmonton	Capital Care Grandview	*	CC
Edmonton	Capital Care Lynnwood	*	CC
Edmonton	Capital Care Norwood	*	CC
Edmonton	Christenson Developments Devonshire Manor		SL
Edmonton	Cross Cancer Institute	*	A
Edmonton	Devonshire Care Centre		CC
Edmonton	Edmonton Chinatown Care Centre		CC,SL
Edmonton	Edmonton General Continuing Care Centre		CC
Edmonton	Edmonton People In Need #4 - Batoma House		SL
Edmonton	Emmanuel Home		SL
Edmonton	Excel Society - Grand Manor		SL
Edmonton	Extendicare Holyrood		CC
Edmonton	Extendicare Somerset		CC
Edmonton	George Spady Centre Society		O
Edmonton	Glenrose Rehabilitation Hospital	*	A
Edmonton	Good Samaritan Dr. Gerald Zetter Care Centre		CC
Edmonton	Good Samaritan Wedman House		SL
Edmonton	Grey Nuns Community Hospital		A
Edmonton	Innovative Housing - Gravelle		SL
Edmonton	Innovative Housing – Villa Marguerite		SL
Edmonton	Jellinek House		O
Edmonton	Jubilee Lodge Nursing Home		CC

*Operated by AHS

** A = Acute care facility, CC = Continuing care facility, P = Psychiatric facility, SL = Supportive Living, O = Other

Edmonton and Area (continued)

Location	Facility		Facility Type** A/CC/P/ SL/O
Edmonton	Kensington Village Continuing Care Centre		CC,SL
Edmonton	Lifestyle Options - Leduc		SL
Edmonton	Lifestyle Options - Riverbend		SL
Edmonton	Lifestyle Options - Terra Losa		SL
Edmonton	McDougall House		O
Edmonton	Misericordia Community Hospital		A
Edmonton	Our House		O
Edmonton	Oxford House		O
Edmonton	Recovery Acres Edmonton		O
Edmonton	Revera Retirement LP - Churchill		SL
Edmonton	Revera Retirement LP - Riverbend		SL
Edmonton	Rosedale Estates		SL
Edmonton	Rosedale Griesbach		SL
Edmonton	Royal Alexandra Hospital	*	A
Edmonton	Salvation Army Grace Manor		SL
Edmonton	Salvation Army Supportive Residence		SL
Edmonton	Shepherd's Care Foundation - Garden		SL
Edmonton	Shepherd's Care Foundation - Golden Age Manor		SL
Edmonton	St. Joseph's Auxiliary Hospital		CC
Edmonton	St. Michael's Long Term Care Centre		CC
Edmonton	St. Thomas Health Centre		SL
Edmonton	Stollery Children's Hospital	*	A
Edmonton	The Dianne and Irving Kipnes Centre for Veterans	*	CC
Edmonton	The Waterford of Summerlea (Retirement Home)		SL
Edmonton	Touchmark at Wedgewood		CC
Edmonton	University of Alberta Hospitals	*	A
Edmonton	Venta Care Centre		CC
Edmonton	Wildrose Cottage (Chartwell Seniors Housing)		SL
Fort Saskatchewan	Fort Saskatchewan Health Centre	*	A
Fort Saskatchewan	Rivercrest Care Centre		CC
Leduc	Extendicare Leduc		CC
Leduc	Leduc Community Hospital	*	A,CC
Leduc	Salem Manor Nursing Home		CC
Morinville	Aspen House	*	SL
Redwater	Redwater Health Centre	*	A,CC
Sherwood Park	All Seniors Care Summerwood		SL
Sherwood Park	Capital Care Strathcona	*	CC,SL
Sherwood Park	Country Cottage - Chartwell		SL
Sherwood Park	Sherwood Park Care Centre		CC
Spruce Grove	Good Samaritan Spruce Grove Centre		SL
St Albert	Poundmaker's Lodge Treatment Centre		O
St. Albert	Citadel Care Centre		CC
St. Albert	Sturgeon Community Hospital	*	A
St. Albert	Youville Auxiliary Hospital (Grey Nuns) of St. Albert		CC
Stony Plain	Good Samaritan George Hennig Place		SL
Stony Plain	The Good Samaritan Stony Plain		CC,SL
Stony Plain	WestView Health Centre - Stony Plain	*	A,CC
Various	Family Care Homes		O
Various	Mental Health Care Homes		O
Various	Personal Care Homes		SL
Villeneuve	West Country Hearth		SL

Fort McMurray and Area

Location	Facility		Facility Type** A/CC/P/ SL/O
Fort McMurray	Northern Lights Regional Health Centre	*	A,CC
Fort McMurray	Pastew Place Detox Centre		O
Fort Vermilion	St. Theresa General Hospital	*	A,CC
High Level	Action North Recovery Centre		O
High Level	Northwest Health Centre	*	A,CC
La Crete	La Crete Continuing Care Centre	*	CC

*Operated by AHS

** A = Acute care facility, CC = Continuing care facility, P = Psychiatric facility, SL = Supportive Living, O = Other

Grande Prairie and Area

Location	Facility		Facility Type** A/CC/P/ SL/O
Beaverlodge	Beaverlodge Municipal Hospital	*	A
Fairview	Fairview Health Complex	*	A,CC
Fox Creek	Fox Creek Healthcare Centre	*	A
Grande Cache	Grande Cache Community Health Complex	*	A,CC
Grande Prairie	Business & Industry Clinic	*	O
Grande Prairie	Northern Addiction Centre	*	O
Grande Prairie	Grande Prairie Care Centre		CC
Grande Prairie	Queen Elizabeth II Hospital	*	O
Grande Prairie	The Gardens at Emerald Park		SL
Grimshaw	Grimshaw/Berwyn & District Community Health Centre	*	CC
High Prairie	High Prairie Health Complex	*	A,CC
High Prairie	MITAA Centre		O
Hythe	Hythe Continuing Care Centre	*	CC
Manning	Manning Community Health Centre	*	A,CC
McLennan	Manoir du Lac		CC,SL
McLennan	Sacred Heart Community Health Centre	*	A
Peace River	Peace River Community Health Centre	*	A,CC
Spirit River	Central Peace Health Complex	*	A,CC
Valleyview	Valleyview Health Centre	*	A,CC

Jasper to Cold Lake

Location	Facility		Facility Type** A/CC/P/ SL/O
Athabasca	Athabasca Healthcare Centre	*	A,CC
Athabasca	Extendicare Athabasca		CC
Barrhead	Barrhead Healthcare Centre	*	A
Barrhead	Dr. W.R. Keir – Barrhead Continuing Care Centre	*	CC
Barrhead	Mental Health Spaces		O
Barrhead	Shepherd's Care Barrhead		SL
Bonnyville	Bonnyville Healthcare Centre		A,CC
Bonnyville	Bonnyville Indian Metis Rehabilitation Centre		O
Bonnyville	Extendicare Bonnyville		CC
Boyle	Boyle Healthcare Centre	*	A
Cold Lake	Cold Lake Healthcare Centre	*	A,CC
Desmarais	Wabasca/Desmarais Healthcare Centre	*	A
Edson	Edson Healthcare Centre	*	A,CC
Elk Point	Elk Point Healthcare Centre	*	A,CC
Hinton	Hinton Healthcare Centre	*	A
Hinton	Mountain View Centre		SL
Jasper	Evergreen Alpine - Jasper		SL
Jasper	Seton - Jasper Healthcare Centre	*	A
Lac La Biche	William J. Cadzow - Lac La Biche Healthcare Centre	*	A,CC
Mayerthorpe	Extendicare Mayerthorpe		CC
Mayerthorpe	Mayerthorpe Healthcare Centre	*	A,CC
Radway	Radway Continuing Care Centre	*	CC
Slave Lake	Slave Lake Healthcare Centre	*	A,CC
Smoky Lake	George McDougall – Smoky Lake Healthcare Centre	*	A,CC
Smoky Lake	Smoky Lake Continuing Care Centre	*	CC
St Paul	Extendicare St. Paul		CC
St Paul	Mental Health Spaces		O
St Paul	St. Therese - St. Paul Healthcare Centre	*	A,CC
Swan Hills	Swan Hills Healthcare Centre	*	A
Vilna	Vilna Villa		SL
Westlock	Smithfield Lodge		SL
Westlock	Westlock Healthcare Centre	*	A,CC
Whitecourt	Whitecourt Healthcare Centre	*	A

*Operated by AHS

** A = Acute care facility, CC = Continuing care facility, P = Psychiatric facility, SL = Supportive Living, O = Other

Lethbridge and Area

Location	Facility		Facility Type** A/CC/P/ SL/O
Blairmore	Crowsnest Pass Health Centre	*	A,CC
Blairmore	York Creek Lodge		SL
Cardston	Cardston Health Centre	*	O
Cardston	Cardston Lodge		SL
Cardston	Grandview Nursing Home	*	CC
Coaldale	Coaldale Health Centre	*	O
Coaldale	Sunny South Lodge		SL
Fort MacLeod	Extendicare Fort MacLeod		O
Fort MacLeod	Foothills Detox Centre		O
Fort MacLeod	Fort MacLeod Health Centre	*	O
Fort MacLeod	Pioneer Lodge		SL
Lethbridge	Chinook Regional Hospital	*	A
Lethbridge	Columbia House Lethbridge		SL
Lethbridge	Edith Cavell Care Centre		CC
Lethbridge	Extendicare Lethbridge		CC
Lethbridge	Golden Acres		SL
Lethbridge	Good Samaritan Park Meadows Village		O
Lethbridge	Good Samaritan West Highlands		SL
Lethbridge	South Country Treatment Centre		O
Lethbridge	Southern Alcare Manor		O
Lethbridge	St Michael's Health Centre		O
Lethbridge	St Michael's Health Centre - St. Therese Villa		SL
Magrath	Good Samaritan Garden Vista		O
Milk River	Milk River Health Centre	*	O
Milk River	Prairie Rose Lodge		SL
Picture Butte	PChAD Protective Safe House	*	O
Picture Butte	Piyami Lodge		SL
Picture Butte	Piyami Place		O
Pincher Creek	Good Samaritan Pincher Creek Vista Village		O
Pincher Creek	Pincher Creek Health Centre	*	A,CC
Raymond	Raymond Health Centre	*	O
Taber	Clearview Lodge		SL
Taber	Taber Health Centre	*	A,CC

Medicine Hat and Area

Location	Facility		Facility Type** A/CC/P/ SL/O
Bassano	Bassano Health Centre	*	A,CC
Bow Island	Bow Island Health Centre	*	A,CC
Brooks	Brooks Health Centre	*	A,CC
Brooks	Orchard Manor		SL
Medicine Hat	Chinook Village		SL
Medicine Hat	Club Sierra		CC
Medicine Hat	Leisure Way		SL
Medicine Hat	Meadow Lands		SL
Medicine Hat	Medicine Hat Regional Hospital	*	A
Medicine Hat	Riverview Care Centre		CC
Medicine Hat	South Ridge Village		CC,SL
Medicine Hat	The Valleyview		CC,SL
Oyen	Big Country Hospital	*	A,CC

*Operated by AHS

** A = Acute care facility, CC = Continuing care facility, P = Psychiatric facility, SL = Supportive Living, O = Other

Red Deer and Area

Location	Facility		Facility Type** A/CC/P/ SL/O
Bentley	Bentley Care Centre	*	CC
Breton	Breton Health Centre	*	CC
Castor	Our Lady of the Rosary Hospital		A,CC
Consort	Consort Hospital and Care Centre	*	A,CC
Coronation	Coronation Hospital and Care Centre	*	A,CC,SL
Drayton Valley	Drayton Valley Hospital and Care Centre	*	A,CC
Drayton Valley	Serenity House	*	SL
Drumheller	Drumheller Health Centre	*	A,CC
Drumheller	Grace House		O
Eckville	Eckville Manor House		SL
Hanna	Hanna Health Centre	*	A,CC
Innisfail	Innisfail Health Centre	*	A,CC
Lacombe	Lacombe Hospital and Care Centre	*	A,CC
Lacombe	Manor at Royal Oak Village (Good Samaritan Society)		SL
Linden	Linden Nursing Home		CC
Olds	Olds Hospital and Care Centre	*	A,CC
Olds	Sunrise Village Olds (Continuum HealthCare Corp)		SL
Ponoka	Centennial Centre for Mental Health and Brain Injury	*	P
Ponoka	Northcott Care Centre (Ponoka)		CC
Ponoka	Ponoka Hospital and Care Centre	*	A,CC
Ponoka	Sunrise Village Ponoka (Continuum HealthCare Corp)		SL
Red Deer	Bethany CollegeSide (Red Deer)		CC
Red Deer	Kentwood Place	*	O
Red Deer	Pines Lodge - Piper Creek Foundation		SL
Red Deer	Red Deer Nursing Home	*	CC
Red Deer	Red Deer Regional Hospital Centre	*	A
Red Deer	Safe Harbour Society		O
Red Deer	Valley Park Manor (Red Deer)	*	CC
Rimbey	Rimbey Hospital and Care Centre	*	A,CC
Rocky Mountain House	Clearwater Centre (Rocky Mountain House)		CC,SL
Rocky Mountain House	Rocky Mountain House Health Centre	*	A
Stettler	Stettler Hospital and Care Centre	*	A,CC
Sundre	Sundre Hospital and Care Centre	*	A,CC
Sylvan Lake	Bethany Sylvan Lake		CC,SL
Three Hills	Three Hills Health Centre	*	A,CC
Trochu	St. Mary's Health Care Centre		CC
Wetaskiwin	Good Shepherd Lutheran Home		SL
Wetaskiwin	Peace Hills Lodge		SL
Wetaskiwin	Sunrise Village Wetaskiwin (Continuum HealthCare Corp)		SL
Wetaskiwin	Wetaskiwin Hospital and Care Centre	*	A,CC

In addition to the facilities listed above, these financial statements also include the operations of community health centres, public health clinics, research facilities, laboratory sites, community rehabilitation physiotherapy clinics, and hemodialysis satellites all operating within the Province.

*Operated by AHS

** A = Acute care facility, CC = Continuing care facility, P = Psychiatric facility, SL = Supportive Living, O = Other

Financial Information

Health Quality Council of Alberta

Financial Statements

March 31, 2010

HEALTH QUALITY COUNCIL OF ALBERTA

FINANCIAL STATEMENTS

MARCH 31, 2010

Statement of Management Responsibility

Auditor's Report

Statement of Financial Position

Statement of Operations

Statement of Changes in Net Assets

Statement of Cash Flows

Notes to the Financial Statements

Schedule 1 – Schedule of Expenses by Object

Schedule 2 - Schedule of Salaries and Benefits

HEALTH QUALITY COUNCIL OF ALBERTA

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

FINANCIAL STATEMENTS

MARCH 31, 2010

The accompanying financial statements are the responsibility of management and have been reviewed and approved by Senior Management. The financial statements were prepared in accordance with Canadian Generally Accepted Accounting Principles and the financial directives issued by Alberta Health and Wellness, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising written policies, standards, procedures, a formal authorization structure, and satisfactory processes to review internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained, and assets are adequately safeguarded.

The Health Quality Council of Alberta's members carry out their responsibility for the financial statements through the Audit and Finance Committee. This Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the financial statements to the Health Quality Council of Alberta for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Audit and Finance Committee.

The Auditor General of Alberta provides an independent audit of the financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the financial statements prepared by management.

[Original signed by]

Chief Executive Officer
Dr. John Cowell
June 14, 2010

[Original signed by]

Executive Director
Charlene McBrien-Morrison
June 14, 2010

AUDITOR GENERAL
Alberta

Auditor's Report

To the Members of the Health Quality Council of Alberta and the Minister of Health and Wellness

I have audited the statements of financial position of the Health Quality Council of Alberta as at March 31, 2010 and 2009 and the statements of operations, changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the Council's management. My responsibility is to express an opinion on these financial statements based on my audits.

I conducted my audits in accordance with Canadian generally accepted auditing standards. Those standards require that I plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In my opinion, these financial statements present fairly, in all material respects, the financial position of the Council as at March 31, 2010 and 2009 and the results of its operations and its cash flows for the years then ended in accordance with Canadian generally accepted accounting principles.

[Original signed by Merwan N. Saher]
CA
Auditor General

Edmonton, Alberta
June 14, 2010

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF FINANCIAL POSITION
March 31
(in thousands)

	2010 Actual	2009 Actual
ASSETS		
Cash and cash equivalents (Note 3)	$ 1,703	$ 1,649
Accounts receivable	48	154
Prepaid expenses	4	1
Capital assets	33	76
TOTAL ASSETS	$ 1,788	$ 1,880
LIABILITIES AND NET ASSETS		
Liabilities		
Accounts payable and accrued liabilities (Note 6)	$ 228	$ 428
Accrued vacation pay	106	128
Deferred contributions (Note 4)	808	808
	1,142	1,364
Net assets		
Accumulated surplus	613	440
Investment in capital assets	33	76
TOTAL NET ASSETS	646	516
TOTAL LIABILITIES AND NET ASSETS	$ 1,788	$ 1,880

The accompanying notes and schedules are part of these financial statements.

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF OPERATIONS
March 31
(in thousands)

	2010		2009
	Budget	Actual	Actual
REVENUE			
Alberta Health and Wellness contributions	$ 4,026	$ 4,026	$ 4,243
Investment and other income	1,144	172	185
TOTAL REVENUE	5,170	4,198	4,428
EXPENSES (Schedule 1)			
Administration	5,031	3,862	4,315
Information technology	139	206	140
TOTAL EXPENSES	5,170	4,068	4,455
Excess (deficiency) of revenue over expenses	$ -	$ 130	$ (27)

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF CHANGES IN NET ASSETS
March 31
(in thousands)

	2010			2009
	Accumulated surplus/(deficit) (Note 8)	Investment in capital assets	Total	Total
Balance at beginning of year	$ 440	$ 76	$ 516	$ 543
Excess (deficiency) of revenue over expense	130	-	130	(27)
Capital assets purchased with internal funds	(25)	25	-	-
Amortization of internally funded capital assets	68	(68)	-	-
Balance at end of year	$ 613	$ 33	$ 646	$ 516

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF CASH FLOWS
March 31
(in thousands)

	2010		2009
	Budget	Actual	Actual
Cash generated from (used by):			
Operating Activities:			
Excess (deficiency) of revenue over expenses	$ -	$ 130	$ (27)
Non-cash transactions:			
Amortization	79	68	93
Changes in non-cash working capital account	(893)	(119)	(278)
Cash generated from (used by) operating activities:	(814)	$79	(212)
Cash used by investing activities	(40)	(25)	(142)
Cash generated from financing activities	-	-	-
Increase (decrease) in cash and cash equivalents	(854)	54	(354)
Cash and cash equivalents, beginning of year	1,649	1,649	2,003
Total cash and cash equivalents, end of year	$ 795	$ 1,703	$ 1,649

HEALTH QUALITY COUNCIL OF ALBERTA
NOTES TO THE FINANCIAL STATEMENTS
MARCH 31, 2010
(In thousands)

Note 1 Authority, Purpose and Operations

The Health Quality Council of Alberta (HQCA) was established July 1, 2006 under the Alberta Regional Health Authorities Act. The HQCA is considered not-for-profit under the Income Tax Act and exempt from payment of income tax.

The HQCA is engaged in promoting and improving patient safety and health service quality across Alberta.

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

(1) The financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and the reporting requirements of Alberta Health and Wellness' Financial Directive HQCA 1.

(2) These financial statements use the deferral method of revenue recognition.

(b) Financial Instruments

The HQCA has classified its financial assets and financial liabilities as held-for-trading. Financial assets and liabilities classified as held-for-trading are measured at fair value with changes in their value (unrealized gains or losses) recorded in "net income" in the Statement of Operations. Unrealized gains or losses from changes in fair value or realized gains or losses on disposal are accounted for as investment income. Any interest earned (or incurred) is recognized on an accrual basis as interest income (or expense).

(c) Employee Future Benefits

The HQCA participates in the Local Authorities Pension Plan. This multi-employer defined benefit pension plan provides pensions for participating employees based on years of service and earnings. Defined contribution plan accounting is applied where the HQCA has insufficient information to apply defined benefit plan accounting.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Pension costs comprise the employer's contributions during the year, based on rates expected to provide benefits payable under the pension plans. The Council does not record its portion of the plan's deficit or surplus.

(d) Capital Assets

Capital assets are recorded at cost. Capital assets with unit costs less than five thousand dollars are expensed. Capital assets are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Computer Assets	2 years
Office Equipment	3 years

Leasehold improvements are amortized over the life of the lease.

(e) Measurement Uncertainty

The financial statements, by their nature, contain estimates and are subject to measurement uncertainty. The amounts recorded for amortization of capital assets are based on estimates of the useful life of the related assets. Actual results could differ from estimates.

Note 3 Cash and Cash Equivalents

The cash and cash equivalents balance includes a Guaranteed Investment Certificate (GIC) of $502 (2009: $0).

Note 4 Deferred Contributions

The balance at the end of the year is restricted for the following purposes:

	2010	2009
Long Term Care Survey	$ 33	$ 33
Research on Quality and Safety	250	250
Medication Management in LTC	525	525
Total	$ 808	$ 808

Note 5 Pension Expense

Pension expense recorded in the financial statements is equivalent to the HQCA's annual contribution payable of $131 for the year ended March 31, 2010 (2009 $119.)

At December 31, 2009, the Local Authorities Pension Plan reported a deficit of $3,998,614 (2008 deficit of $4,413,971).

Note 6 Accounts Payable and Accrued Liabilities

The Health Quality Council of Alberta has accrued a potential liability of $65 in relation to operating and realty tax expense for the lease of its Calgary office. Payment is subject to the receipt of further information from the landlord.

Note 7 Commitments and Contingencies

The Health Quality Council of Alberta is committed to contract payments in future years as follows:

2010/2011	$ 760
2011/2012	586
2012/2013	526
2013/2014	257
	$2,129

An "Assignment of Partial Leasehold Interest" agreement was put into place for April 1, 2007 to June 30, 2011. This commits the Health Quality Council of Alberta to annual rent in the amount of $132 and operating & realty tax expense recoverable by the landlord, subject to adjustment in accordance with the lease of approximately $94 annually.

The Health Quality Council of Alberta signed a 5 year lease for office space in Edmonton with annual rent in the amount of $47 and operating & realty tax expense recoverable by the landlord, subject to adjustment in accordance with the lease of approximately $24 annually.

The Health Quality Council of Alberta has a commitment with Dr. John W. Cowell Consulting Ltd. to receive executive oversight. The value of the commitment as at March 31, 2010 is $38 per month and extends until October 2013.

Note 8 Budget

The budget was approved by the Health Quality Council of Alberta on June 24, 2009, and submitted to the Minister of Health and Wellness.

Note 9 Accumulated Surplus

The accumulated surplus arose because of hiring delays, unfilled employee positions, projects that were under budget, in addition to delayed project starts.

Note 10 Related Parties

(a) Province of Alberta and Alberta Health Services

The Minister of Health and Wellness appoints the members of the Health Quality Council of Alberta. The Council is economically dependent on the Ministry of Health and Wellness since the viability of its operations depends on contributions from the Ministry.

The HQCA had the following transactions with Alberta Health Services recorded on the Statements of Operations and Financial Position:

	2010				2009			
	Revenue	Expense	Receivable	Payable	Revenue	Expense	Receivable	Payable
	164	-	38	-	127	49	105	-
Total	$ 164	$ -	$ 38	$ -	$ 127	$ 49	$ 105	$ -

Note 11 Comparative Figures

Certain 2009 figures have been reclassified to match their 2010 presentation.

Note 12 Approval of Financial Statements

These financial statements were approved by the Health Quality Council of Alberta Board.

Schedule 1

HEALTH QUALITY COUNCIL OF ALBERTA
SCHEDULE OF EXPENSES BY OBJECT
March 31
(in thousands)

	2010 Budget	2010 Actual	2009 Actual
Salaries and Benefits (Schedule 2)	$ 2,502	$ 2,236	$ 2,078
Other *	2,589	1,764	2,284
Amortization:			
Capital equipment - internally funded	79	68	93
	$ 5,170	$ 4,068	$ 4,455
*Other:			
Office, General supplies, miscellaneous	$ 576	$ 419	$ 846
Referred Out Services	1,296	696	806
Grants	87	73	214
Lease, Fees and Minor Equipment	241	370	278
Research	250	-	-
Information Technology	139	206	140
	$ 2,589	$ 1,764	$ 2,284

Schedule 2

HEALTH QUALITY COUNCIL OF ALBERTA
SCHEDULE OF SALARIES AND BENEFITS
March 31
(in thousands)

	2010								2009	
	Number of FTEs[1]	Base Salary[2]	Other Cash Benefits[3]	Other Non-Cash Benefits[4]	Sub Total	Number of FTEs	Severance[5]	Total	Number of FTEs[1]	Total
Chair										
L.Tyrrell	-	-	$ 19	-	$ 19	-	-	$ 19	-	$ 15
Members										
R.Johnston	-	-	-	-	-	-	-	-	-	-
T. Klassen	-	-	-	-	-	-	-	-	-	1
B.Laing	-	-	6	-	6	-	-	6	-	6
M.Lee	-	-	5	-	5	-	-	5	-	6
P. Norton	-	-	-	-	-	-	-	-	-	1
L.Steinmann	-	-	7	-	7	-	-	7	-	8
D.Tupper	-	-	13	-	13	-	-	13	-	5
P.Pelton	-	-	6	-	6	-	-	6	-	1
D.Schopflocher	-	-	2	-	2	-	-	2	-	-
C.Skappak	-	-	4	-	4	-	-	4	-	-
J.Birdsell	-	-	3	-	3	-	-	3	-	-
Sub-total	-	-	65	-	65	-	-	65	-	43
Staff										
Chief Executive Officer[6]	1.0	438	43	1	482	-	-	482	1.0	439
CEO Direct Reports (by position)										
Management reporting to CEO										
Direct Reports										
Executive Director	1.0	139	13	22	174	-	-	174	1.0	162
Patient Safety Director	1.0	121	10	18	149			149	1.0	146
Controller	0.3	27	-	6	33	0.3	29	62	1.0	135
Other management	6.2	671	24	121	816	-	-	816	5.9	793
Other staff	7.0	396	15	77	488	-	-	488	5.8	360
Sub Total	16.5	1,792	105	245	2,142	0.3	29	2,171	15.7	2,035
Grand Total	16.5	$ 1,792	$ 170	$ 245	$ 2,207	0.3	$ 29	$ 2,236	15.7	$ 2,078

HEALTH QUALITY COUNCIL OF ALBERTA
SCHEDULE OF SALARIES AND BENEFITS
March 31, 2010

(1) Full Time Equivalent (FTE) is determined at the rate of 2,022.75 annual hours for each full-time employee. Total actual discrete number of individuals employed: 21 (2009: 18). "Discrete" number of individuals refers to all employees who were in the system during the fiscal year.

(2) Base salary includes pensionable base pay as well as statutory and vacation accruals relating to the current fiscal year.

(3) Other cash benefits include bonuses, overtime, lump sum payments and honoraria.

(4) Other non-cash benefits include:

a. Share of all employee benefits and contributions or payments made on behalf of employees including pension, health care, dental coverage, vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short term disability plans, professional membership and tuition and:

b. Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay, financial planning services, retirement planning services, concessionary loans, travel allowances, car allowances and club memberships:

(5) Severance includes direct or indirect payments to individuals upon termination, which are not included in other benefits.

(6) The HQCA's Chief Executive Officer (CEO) is retained through a 7 year executive oversight contract, which holds the HQCA harmless of any related overtime, benefits or supplementary retirement.

Ministry Contacts

For further information regarding the contents of this annual report, please contact:

Position	Name	Phone Number
Minister of Health and Wellness	Gene Zwozdesky	780.427.3665 Fax: 780.415.0961
Deputy Minister of Health and Wellness	Jay Ramotar	780.422.0747 Fax: 780.427.1016
Community and Population Health Assistant Deputy Minister	Margaret King	780.415.2783 Fax: 780.422.3671
Corporate Support Assistant Deputy Minister	Martin Chamberlain	780.422.1045 Fax: 780.422.3672
Financial Accountability Assistant Deputy Minister	David Breakwell	780.415.1599 Fax: 780.422.3672
Health Policy and Service Standards Assistant Deputy Minister	Susan Williams	780.644.3086 Fax: 780.415-0570
Health System Performance and Information Management Acting Assistant Deputy Minister and Chief Information Officer	Mark Brisson	780.427.1572 Fax: 780.422.5176
Health Workforce Assistant Deputy Minister	Glenn Monteith	780.415.2745 Fax: 780.415.8455
Chief Medical Officer of Health	Dr. André Corriveau	780.415.2809 Fax: 780.427.7683
Communications Director	Andy Weiler	780.427.5344 Fax: 780.427.1171
Human Resources Executive Director	Rick Brick	780.427.1060 Fax: 780.422.1700